Supreme Court, U.S.
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No. 91-1223

IN THE

Supreme Court of the United States

October Term, 1991

OHIO DEPARTMENT OF HUMAN SERVICES,
Petitioner,

vs.

OHIO HOSPITAL ASSOCIATION, *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE
SUPREME COURT OF OHIO

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a reduction by a state in existing Medicaid reimbursement rates for outpatient hospital services violates 42 U.S.C. §1396a(a)(30)(A) requiring reimbursement consistent with efficiency, economy, and quality of care.

LIST OF PARTIES

The parties to the proceedings before this Court are:

Petitioner:

OHIO DEPARTMENT OF HUMAN SERVICES, a state agency.

Respondents:

OHIO HOSPITAL ASSOCIATION
GREATER CLEVELAND HOSPITAL ASSOCIATION
HOSPITAL ASSOCIATION OF CENTRAL OHIO
ADAMS COUNTY HOSPITAL
BETHESDA HOSPITAL, INC.
BROWN COUNTY GENERAL HOSPITAL
CHILDREN'S HOSPITAL, COLUMBUS
CHILDREN'S HOSPITAL MEDICAL CENTER, CINCINNATI
CHILDREN'S HOSPITAL MEDICAL CENTER, AKRON
DOCTORS HOSPITAL, COLUMBUS
DOCTORS HOSPITAL, NELSONVILLE
FAIRVIEW GENERAL HOSPITAL
MERIDIA HEALTH SYSTEMS
RIVERSIDE HOSPITAL, TOLEDO
ST. LUKES HOSPITAL ASSOCIATION, CLEVELAND
ST. JOHN HOSPITAL, CLEVELAND
ST. JOSEPH HOSPITAL & HEALTH CENTER, LORAIN
THE CHILDREN'S MEDICAL CENTER, DAYTON
THE MT. SINAI MEDICAL CENTER, CLEVELAND
UNIVERSITY HOSPITALS OF CLEVELAND

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No. _____

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OHIO DEPARTMENT OF HUMAN SERVICES,
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Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE
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PETITION FOR A WRIT OF CERTIORARI

The petitioner, Ohio Department of Human Services, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Ohio Supreme Court entered in the above-entitled proceeding on November 13, 1991.

OPINION BELOW

The opinion of the Ohio Supreme Court is reported at 62 Ohio St. 3d 97 and is reprinted in the appendix hereto, p. A1, *infra.* The decision of the Court of Appeals of Franklin County, Ohio, Tenth Appellate District is unreported and is reprinted in the Appendix hereto, p. A16, *infra.* The decision of the Court of Claims, State of Ohio is unreported and is reprinted in the Appendix hereto, p. A40, *infra.*

JURISDICTION

This cause arose under Ohio Adm. Code 5101:3-2-20 and Title 42, *United States Code* §1396a(a)(30)(A). The Ohio Court of Claims found that it had jurisdiction over this case under §2743.03, Ohio Revised Code. On November 2, 1988, the Ohio Court of Claims granted judgment for the respondents and the petitioner appealed.

Petitioner appealed the decision to the Court of Appeals for Franklin County, Ohio, Tenth Appellate District. On June 21, 1990, the Court of Appeals affirmed the decision of the Court of Claims.

On Petitioner's appeal, the Ohio Supreme Court, on November 13, 1991, affirmed the decision of the Court of Appeals and held that the petitioner enacted Ohio Adm. Code 5101:3-2-20 solely for budgetary reasons and failed to consider the effect on the quality of care provided under the Medicaid program.

The jurisdiction of this Court to review the judgment of the Ohio Supreme Court is invoked under 28 U.S.C. §1257(3).

STATUTE INVOLVED

42 United States Code §1396a(a)(30)(A):

> "Contents. A state plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in §1903(i)(y) [42 USC §1396b(i)(4)]) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy and quality of care."

STATEMENT OF THE CASE

The Ohio Court of Claims found the following facts. Ohio participates in the Medicaid program, a cooperative federal-state program established by Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.*, under which federal funds are provided to states to furnish necessary medical assistance to needy individuals. The Ohio Department of Human Services (ODHS) administers Ohio's Medicaid program pursuant to 42 U.S.C. §1396a and Chapter 5111, Ohio Revised Code. Hospitals participate in Ohio's Medicaid program pursuant to their provider agreements with ODHS, and provide outpatient services to Medicaid recipients, in both clinic and emergency room settings.

Among the methods used by states under the Medicaid program to pay hospitals for outpatient services are payment of charges, cost-based reimbursements, and prospective fee payment. Under the charge-based payment method, a hospital is paid all, or a portion, of the fee established by the hospital for the services rendered. Under the cost-based reimbursement method, a hospital is reimbursed for all, or a portion, of the costs of the resources used directly and indirectly in providing health care services. Under the prospective payment method, a hospital is paid a fixed fee established prospectively by the state Medicaid agency for services rendered subsequent to establishment of the fee.

The events leading to the adoption of Ohio Adm. Code 5101:3-2-20 began in 1986, during ODHS' preparation of the Medicaid budget for the budget biennium beginning July 1, 1987, and ending June 30, 1989. ODHS decided upon a policy for reimbursement of hospital outpatient services for that biennium that

included changing the reimbursement methodology from a retrospective 100 percent of cost basis to a prospective fee for service basis. ODHS projected that funds expended under the new methodology would be 10 percent less than what was projected to be spent under the 100 percent of cost basis.

There were three primary reasons for ODHS' decision to change the reimbursement methodology for hospital outpatient services. First, the 100 percent of cost reimbursement method provided no incentive to hospitals to minimize costs, and provided an incentive for hospitals to exercise discretion to allocate costs to outpatient services and away from inpatient services that are reimbursed on a prospective fee payment basis. Second, converting to a fee for service methodology places hospitals on the same basis used for reimbursing physicians and other outpatient service providers, thereby alleviating the large and growing disparity in the amount of payment for identical services between provider groups. Third, placing hospitals on a fee for service basis encourages health care providers to increase the provision of outpatient services to Medicaid patients in more cost-effective settings and decrease the use of less cost-effective hospital facilities for the provision of such services.

In preparing the budget for the biennium ending June 30, 1989, ODHS presumed that the fee for service reimbursement method for hospital outpatient services would be in place by October, 1987, and that the method would achieve the full 10 percent cost savings. The budget prepared and submitted to the Ohio Office of Budget and Management ("OBM") contained the 10 percent cost savings estimate. OBM in turn submitted a Medicaid budget containing the 10 percent savings

estimate to the Ohio General Assembly. The Ohio General Assembly was advised during the legislative process that the proposed budget incorporated the 10 percent savings estimate. The budget appropriation enacted by the Ohio General Assembly for the biennium ending June 30, 1989, provided 10 percent less funding for hospital outpatient services than the level of funding that would have been provided for a retrospective cost-based methodology.

The budget assumption incorporated by the Ohio General Assembly was that the starting date for initiation of the prospective fee system by ODHS would be October, 1987. It was not, however, until January 4, 1988, halfway through the first year of the budget biennium, that the fee for service rule implementing the new system was proposed. As of that date, in order to meet the 10 percent reduction built into the budget, ODHS would have to impose a 17-20 percent reduction in hospital outpatient reimbursement for the remaining six months in fiscal year 1988. ODHS concluded that a 17-20 percent cut was too abrupt under the circumstances, and decided to impose a 12 percent reduction through promulgation of emergency rule Ohio Adm. Code 5101:3-2-20 while endeavoring to complete the process of adopting the new fee for service rule.

On January 4, 1988, ODHS adopted Ohio Adm. Code 5101:3-2-20 (Appendix A72) as an emergency rule having immediate effect. Ohio Adm. Code 5101:3-2-20 states, in pertinent part as follows:

> Effective with the date of this rule, payments for outpatient hospital services reimbursed on a cost-related basis will be limited to the lessor of eighty-eight percent of reasonable costs as such costs are described in paragraphs (B) and (C) to (C)(1)(f) of

Rule 5101:3-2-20 of the Administrative Code or eighty-eight percent of billed charges for services furnished to eligible recipients.

The proposed prospective fee rule for hospital outpatient services was submitted to the Joint Committee for Agency Rule Review ("JCARR") of the Ohio General Assembly, which was empowered to recommend that the Ohio General Assembly reject the rule and prevent its adoption. Respondent Ohio Hospital Association and its members actively opposed the rule at JCARR. The Chairman of JCARR advised ODHS, that the rule would not be approved at JCARR due to hospital opposition, and requested that it be withdrawn. To retain good relations with JCARR, and to avoid forcing the members of JCARR to cast a vote on a controversial issue that the members desired not to cast, and to avoid the mandatory waiting period prescribed by §119.03(H)(3), Revised Code, for reproposing a rule that has been rejected by the Ohio General Assembly, ODHS acceded to the Chairman's request, and withdrew the proposed fee for service rule.

Given the inability to adopt a fee for service rule over the opposition of the Ohio Hospital Association and its member hospitals, ODHS, facing expiration of the emergency rule on March 31, 1988, again adopted the rule on an emergency basis. On April 13, 1988, ODHS adopted Ohio Adm. Code 5101:3-2-20 as a permanent rule, taking effect on April 23, 1988 (Appendix A75). The permanent rule provided that the 12 percent reduction would stay in place through June 30, 1988. For the ensuing year, ending June 30, 1989, the reduction was set at 8 percent. The rule provided for no reduction after that date, thus restoring full cost reimbursement beginning July 1, 1989.

The permanent version of Ohio Adm. Code 5101:3-2-20, effective April 23, 1988, was submitted to JCARR. JCARR did not recommend that the Ohio General Assembly prevent the rule from becoming effective, nor did the Chairman of JCARR request that the rule be withdrawn, thereby acquiescing in the reduced reimbursement for hospital outpatient services. The percent of cost reduction embodied in Ohio Adm. Code 5101:3-2-20 was submitted to the Health Care Financing Administration of the United States Department of Human Services, and approved as part of the State's medical assistance plan on April 20, 1988, with an effective date of January 4, 1988.

The interim methodology embodied in Ohio Adm. Code 5101:3-2-20 was intended to obtain some of the 10 percent reduction for hospital outpatient services that was incorporated in the State's budget. It could not, however, obtain all of the savings that would have resulted from a 10 percent reduction. The 12 percent reduction for the period January 4, 1988, through June 30, 1988, constituted only a 6 percent reduction for the entirety of that fiscal year. The reduction for the fiscal year ending June 30, 1989, was in reality only 8 percent.

Prior to adopting Ohio Adm. Code 5101:3-2-20, ODHS assessed whether the reduction would adversely impact the availability and quality of hospital outpatient care to Medicaid recipients, and concluded that there would be no adverse impact. ODHS also assessed the financial impact upon the approximately 200 hospitals providing outpatient services to Medicaid patients. The analysis assumed a 10 percent reduction, and concluded that the reduced revenue would be .2 percent of the total cost of all hospitals of providing all services to all patients, and range from .1 percent to .9 percent for

individual hospitals. ODHS concluded that this impact was minor and could be withstood by the hospitals for the short duration of the percent of cost methodology. Because the actual reduction is 6 percent annualized over all fiscal year 1988, and 8 percent for fiscal year 1989, the actual impact is less than the estimate. The aggregate reduction of hospital outpatient service costs resulting from the reduction of Ohio Adm. Code 5101:3-2-20 during the period from January 4, 1988 through June 30, 1989 was, at time of trial, estimated to total $16,600,000.

REASON FOR GRANTING THE WRIT

I. The Decision Of The Ohio Supreme Court Incorrectly Interprets And Applies 42 U.S.C. §1396a(a)(30)(A).

The Ohio Supreme Court's construction and application of 42 U.S.C. §1396a(a)(30)(A) is in conflict with the specific language of the statute and its legislative history.

During the period of time affected by the OAC 5101:3-2-20 rate reduction at issue in this case 42 U.S.C. §1396a(a)(30)(A) provided that state medical assistance plans should "provide such methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care." The Ohio Supreme Court held that OAC 5101:3-2-20 violated that provision. The court reasoned that ODHS may not reduce Medicaid rates without adequate analysis of the effect of the reduction upon "quality of care," and that ODHS' analysis in this case was insufficient. The logical promise of the court's reasoning is that a rate reduction that adversely affects "efficiency, economy, and quality of care" is unlawful under §1396a(a)(30)(A).

The Ohio Supreme Court's construction and application of the statute is erroneous as a matter of law, for the United States Department of Health and Human Services and other courts that have considered the question have held that §1396a(a)(30)(A) does not impose upon state Medicaid agencies a substantive obligation to set provider rates at a minimum level.

The legislative history of §1396a(a)(30)(A) plainly reveals that it mandates no permissible minimum rate. As initially enacted in 1968, that section provided that the plan must "assure that payments are *not in excess of reasonable charges* consistent with efficiency, economy, and quality of care." 81 Stat. 911 (emphasis added.) The emphasized language, deleted in subsequent legislation, clearly prescribed only an upper limit on Medicaid rates, and no lower limit. The regulation of the United States Department of Health and Human Services ("USDHHS") governing outpatient hospital services, 42 C.F.R. §447.321, reflected that, by prescribing only an "upper limit" of payment for such services.

§1396a(a)(30)(A) was amended by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, at 86 Stat. 1416, to delete the emphasized language. But the purpose in doing so was not to establish a minimum permissible rate, but rather to delete the upper limit on rates imposed by the deleted language. This is clear from §6327 of the Senate bill, S. 1377, at page 254, containing the language ultimately enacted, and entitling that section "Removal of Medicare Reasonable Charge Limitation." Thus, clearly, the upper rate limit was being removed, without suggestion of a rate floor being enacted.

That the 1981 amendment of (30)(A) was not intended to establish a rate floor is also clear from USDHHS rulemaking that implemented P.L. 97-35, USDHHS also regarded the change to (30)(A) as a ceiling deletion only, starting at 46 Fed. Reg. 48556, 48557 (Oct. 1, 1981):

> Before the implementation of Pub. L. 97-35, the Omnibus Budget Reconciliation Act of 1981, a Medicaid agency's reimbursement level for

> noninstitutional services such as physicians' services, laboratory services, and supplies and equipment (including equipment servicing) could not exceed the reasonable charges established under Medicaid and Medicare. Section 1902(a)(30) [codified at 42 U.S.C. Section 1396a(a)(30)] of the Social Security Act required that State plans for medical assistance must provide assurance that payments were not in excess of reasonable charges consistent with efficiency, economy, and quality of care.
>
> * * *
>
> Section 2174, Pub. L. 97-35 amended Section 1902(a)(30) of the Act to remove the legislative requirements that payments under Medicaid not exceed reasonable charges, and deleted paragraph (1) of Section 1903(i) of the Act to remove the legislative requirement that Medicaid use the reasonable charge established by Medicare as the upper limit for reimbursing noninstitutional services.
>
> Congress removed the Medicaid and Medicare reasonable charge levels as a ceiling on Medicaid payments because it was aware of the problems cited above, and in recognition of states' need for flexibility in their Medicaid programs. Congress expects the removal of the administrative burdens imposed on States by the proper law to improve States' administration of their Medicaid programs and to provide States with the flexibility needed to create incentives to improve the availability and utilization of physicians services under Medicaid [House Budget Committee Report, No. 97-158, page 312]. With the removal of the reasonable charge limits, States can structure their payment levels to fit their specific needs.

Thus, 42 C.F.R. §447.321 was not amended to add a new rate floor. This construction of (30)(A) as not prescribing a rate floor, even as amended in 1981, was deserving of

substantial deference by the Ohio Supreme Court. As held by this Court, interpretation of a statute by the administrative agency charged with its implementation and enforcement is to be given great weight by the courts, *Ford Motor Credit Co. v. Milhollin*, 444 U.S. 555 (1980). Accordingly, DHHS' construction of (30)(A) should control here.

Five courts have held that 42 U.S.C. §1396a(a)(30)(A) prescribes no minimum Medicaid rates, but only an *upper* limit on rates. In *Charleston Memorial Hospital v. Conrad*, CCH Medicare/Medicaid Guide, Paragraph 31,958 (D.S.C., 1982), the court examined (30)(A) in the context of its implementing regulation, 42 C.F.R. §447.321, entitled "Outpatient Hospital Services and Clinic Services: Upper Limits of Payment." The court concluded, at CCH Paragraph 31,958, page 9648, "The plaintiffs have challenged the revised rate of reimbursement for outpatient hospital services . . . as being out of compliance with federal law. However, the court finds that there is no minimum requirement in the applicable Medicaid law for rates of reimbursement for outpatient services. The regulations impose certain upper limits only. . . ."

In accord is *Michigan Hospital Ass'n. v. Dept. of Social Services*, 555 F. Supp. 675 (E.D. Mich., 1983), in which the court noted that only §447.321 applies to hospital outpatient service payments, and it "relates to the upper limits of payments." Earlier cases agree. In *Pennsylvania Pharmaceutical Ass'n. v. Pennsylvania Department of Public Welfare*, 542 F. Supp. 1349 (W.D. Pa., 1982), the court rejected a challenge under (30)(A) to a reduced rate to pharmacists, holding that (30)(A), as amended in 1981, "imposes no duty on states to make minimum payments to pharmacists," page 1351, note 2.

In accord are *Briarcliff Haven, Inc. v. Dept. of Human Services*, 403 F. Supp. 1355 (N.D. Ga., 1975), and *Ostrow Pharmacies, Inc. v. Beal*, 394 F. Supp. 22 (E.D. Pa. 1975).

The Ohio Supreme Court erroneously extends the meaning of 42 U.S.C. §1396a(a)(30)(A) from a ceiling on the upper limits of reimbursement to a requirement that Ohio adequately reimburse medicaid providers of outpatient hospital services. In order to reach that conclusion, the Ohio Supreme Court appears to have incorrectly applied to this case the requirements of 42 U.S.C. §1396a(a)(13)(A) (the Boren Amendment[1]) and this Court's decision interpreting the Boren Amendment, *Wilder v. Virginia Hospital Association* (1990), 496 U.S. _____, 110 S. Ct. 2510, 110 L. Ed. 2d 455.

This case involves a reduction in reimbursement for outpatient hospital services. The Boren Amendment and the Court's decision in *Wilder* are only applicable to the reimbursement of *inpatient* hospital services. Indeed the

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[1] As referred to in this petition the relevant provisions of the Boren Amendment, 42 U.S.C. §1396a(a)(13)(A) read:

> "(a) Contents.
> "*** A State plan for medical assistance must—
> "***
> "(13) provide—
>
> "(A) for payment *** of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State ***) *** which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access *** to inpatient hospital services of adequate quality ***."

Courts of Appeals for the Second and Fifth Circuits as well as the United States District Court for the Eastern District of Michigan have held that the Boren Amendment does not apply to the reimbursement of outpatient hospital services. *State of New York v. Bowen*, 811 F.2d 776 (2nd Cir., 1987); *Charleston Memorial Hospital v. Conrad*, 693 F.2d 324 (4th Cir., 1983); *Michigan Hospital Ass'n. v Department of Social Services*, 555 F. Supp. 675 (E.D. Mich., 1983). The Ohio Supreme Court appears to have erroneously engraphed the requirements of the Boren Amendment onto 42 U.S.C. §1396a(a)(30)(A) in order to conclude that ODHS' reduction in reimbursement to outpatient hospital services violated 30(A).

The Ohio Supreme Court's conclusion effectively bars any reduction in the level of reimbursement for outpatient hospital services by finding that reimbursement at a level below that which was previously considered adequate is a failure to adequately compensate providers which has a *per se* adverse impact on "quality of care." Such an application is contrary to the plain meaning of the statute. Therefore, this Court must decide whether a state may reduce Medicaid reimbursement rates for outpatient hospital services without being in violation of 42 U.S.C. §1396a(a)(30)(A).

CONCLUSION

The decision of the Ohio Supreme Court conflicts with decisions of the federal courts interpreting the requirements of 42 U.S.C. §1396a(a)(30)(A). The Ohio Supreme Court's decision effects the administration of the Medicaid program by the Ohio Department of Human Services and impacts the proper allocation of limited state resources. The Ohio Supreme Court's decision also sets an erroneous precedent which could affect the administration of Medicaid programs by states other than Ohio. For these reasons, a writ of certiorari should be issued to the Ohio Supreme Court to review the question presented by this Petition.

Respectfully submitted,

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APPENDIX

DECISION OF THE SUPREME COURT OF OHIO

(Decided November 13, 1991)

No. 90-1580

THE SUPREME COURT OF OHIO

OHIO HOSPITAL ASSOCIATION, *et al.*,
Appellees,

vs.

OHIO DEPARTMENT OF HUMAN SERVICES,
Appellant.

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[97] [Cite as *Ohio Hosp. Assn. v. Ohio Dept. of Human Services* (1991), 62 Ohio St.3d 97.]

Medical assistance programs—Former Ohio Adm.Code 5101:3-2-20 violates Title XIX of the Social Security Act, Section 1396a(a)(30)(A), Title 42, U.S.Code—Former R.C. 5111.02(D) also violates state law in failing to meet Medicaid state requirements—Reimbursement of monies withheld pursuant to an invalid administrative rule is equitable relief, not money damages.

1. Former Ohio Adm.Code 5101:3-2-20 violates Title XIX of the Social Security Act, Section 1396a(a)(30)(A), Title 42, U.S.Code, because it was implemented solely for budgetary reasons, without consideration of its effect on the quality of care provided by the Medicaid program.

See: West's Ohio Digest, Social Security and Public Welfare 241.90.

2. Former R.C. 5111.02(D) incorporates the requirements of the Social Security Act, and former Ohio Adm.Code 5101:3-2-20 also violates state law because it does not meet the requirements of the Medicaid statute.

See: West's Ohio Digest, Social Security and Public Welfare 241.60, 241.90.

3. The reimbursement of monies withheld pursuant to an invalid administrative rule is equitable relief, not money damages.

See: West's Ohio Digest, States 191(1.19).

(No. 90—1580—Submitted September 17, 1991—Decided November 13, 1991.)

APPEAL from the Court of Appeals for Franklin County, No. 88AP-1034.

On April 23, 1988, the Ohio Department of Human Services ("ODHS") adopted former Ohio Adm.Code 5101:3-2-20, which reduced the Medicaid reimbursement rate for outpatient services to eighty-eight percent of reasonable costs for the year ending June 30, 1988. The reimbursement rate for the following year was set at ninety-two percent of reasonable costs.[1] The rule [98] was

[1] The applicable portion of former Ohio Adm.Code 5101:3-2-20 is:

"*** Limits on reimbursement for outpatient hospital services

"Effective with the date of this rule, payments for outpatient hospital services reimbursed on a cost-related basis will be limited to the lesser of eighty-eight per cent of reasonable costs as such costs are described in paragraphs (B) and (C) to (C)(1)(f) of rule 5101:3-2-22 of the Administrative Code or eighty-eight per cent of billed charges for services furnished to eligible recipients. Effective July 1, 1988, the per cent described in this paragraph is revised from eighty-eight to ninety-two. Services reimbursed on a cost-related basis which are subject to the provisions of this rule include all covered outpatient hospital services except laboratory services which are reimbursed in accordance with rule 5101:3-1-60 of the Administrative Code and, effective July 1, 1988, radiology services which are subject to the provisions of rule 5101:3-2-21 of the Administrative Code."

adopted to prevent an anticipated budget shortfall for the fiscal year ending on June 30, 1988 and the two-year budgetary period ending June 30, 1989.

ODHS claims that the reduced reimbursement rates were necessary because the department was unable to get approval in change from retrospective cost reimbursement for outpatient services to a prospective fee-for-service basis.[2] ODHS estimated that the new reimbursement method would produce a ten-percent reduction in Medicaid outpatient costs and used this figure in the budget that it submitted to the Office of Budget and Management for the two-year period ending June 30, 1989. This budget was submitted to the General Assembly and formed the basis of the Medicaid budget appropriation for July 1, 1987 to June 30, 1989. Although ODHS had originally expected to implement its new reimbursement method in October 1987, it did not propose a rule to do so until January 4, 1988. ODHS subsequently withdrew that rule after the Joint Committee for Agency Rule Review informed ODHS that it was not going to approve the rule and requested that it be withdrawn. ODHS then adopted Ohio Adm.Code 5101:3-2-20, effective on April 23, 1988. This rule replaced two earlier emergency rules, adopted for the

[2] Cost reimbursement and fee-for-service reimbursement are both methods used to reimburse Medicaid providers for services that they have provided to eligible recipients. Former Ohio Adm.Code 5101:3-2-20 covered outpatient services. Traditionally, providers have been reimbursed for one hundred percent of their reasonable costs to perform a covered service, a practice referred to as one-hundred-percent cost reimbursement. Because of different operating costs, this system has led to a disparity in the amounts paid by Medicaid for the same outpatient procedure, depending on whether it was performed at a hospital or in a doctor's office. To alleviate this disparity, ODHS sought to implement a fee-for-service plan, which reimburses providers at a set fee per service performed.

same budgetary reasons, that had also reduced the reimbursement rate to eighty-eight percent of reasonable costs, effective January 4, 1988, and March 31, 1988, respectively.

The Ohio Hospital Association, the Greater Cleveland Hospital Association, the Hospital Association of Central Ohio, and seventeen individual hospitals ("the hospitals") filed their second amended complaint in the Court of Claims on June 17, 1988. The plaintiffs sought a temporary restraining order, an injunction, and monetary relief on the grounds that ODHS had violated their rights under Article VI and the Fourteenth Amendment to the United States [99] Constitution; Section 1983, Title 42, U.S.Code; the Social Security Act, Sections 1395x and 1396a, Title 42, U.S.Code; Sections 1 and 2, Article I, Ohio Constitution; R.C. 119.03; the hospitals' provider agreements; and a settlement agreement between certain of the plaintiffs and defendant from an earlier action.

The Court of Claims held that former Ohio Adm.Code 5101:3-2-20 violated Sections 1396a(a)(2), 1396a(a)(13)(A), 1396a(a)(30), 1395x(v)(1)(A), Title 42, U.S.Code; the Supremacy Clause, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment; Section 2, Article I, Ohio Constitution; the hospitals' provider agreements; and ODHS's duty to act reasonably as an administrative agency. The court allowed suit directly under federal law and the United States Constitution, but did not address the plaintiffs' Section 1983 claim. Additionally, the court found that emergency rule Ohio Adm.Code 5101:3-2-20, adopted on March 31, 1988, violated R.C. 119.93(F), which prohibits an administrative agency from re-adopting an emergency

rule. Lastly, the court held that Ohio Adm.Code 5101:3-2-20 did not violate the parties' settlement agreement from an earlier dispute.

ODHS appealed the judgment and the hospitals cross-appealed on two issues: (1) that they had established a right to relief under Section 1983, Title 42, U.S.Code, and were consequently entitled to attorney fees under Section 1988, Title 42, U.S.Code; and (2) that the promulgation of Ohio Adm.Code 5101:3-2-20 breached the earlier settlement agreement. The Franklin County Court of Appeals affirmed the Court of Claims, overruling all assignments and cross-assignments of error. The court of appeals held that ODHS did not violate the plaintiffs' rights to due process and equal protection, and that it did not breach their contractual rights under the provider agreements. Because the judgment was supported on other grounds, the court held that these were harmless errors.

The cause is now before this court pursuant to the allowance of a motion to certify the record.

Bricker & Eckler, James J. Hughes, Jr. and *Catherine M. Ballard*, for appellees.

Lee I. Fisher, Attorney General; *Rishel, Myers & Kopech, James R. Rishel* and *David E. Northrop*, Special Counsel, for appellant.

[100] WRIGHT, *J.* This case raises the following four issues: (1) whether former Ohio Adm.Code 5101:3-2-20 violates Section 1396a(a)(30)(A), Title 42, U.S.Code; (2) if so, whether the violation of federal Medicaid standards also violates former R.C. 5111.02(D); (3) whether the state is immune from suit for reimbursement of monies withheld under an invalid administrative rule; and (4) whether Section 1983, Title 42, U.S.Code provides the exclusive remedy for alleged violations of the Fourteenth Amendment.

I

ODHS claims that Section 1396a(a)(30)(A), Title 42, U.S.Code does not set a minimum level of payment and thus cannot have been violated by the reduced reimbursement rates of former Ohio Adm.Code 5101:3-2-20). Section 1396a(a)(30)(A), Title 42, U.S.Code provides:

"(a) Contents.

"A State plan for medical assistance must—

"***

"(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan *** as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care."

ODHS is correct in asserting that the statute does not set a minimum rate of reimbursement in recognition of the varying and limited nature of state resources. See *Briarcliff Haven, Inc. v. Dept. of Human Services* (N.D.Ga. 1975), 403 F.Supp. 1355; *Ostrow Pharmacies,*

Inc. v. Beal (E.D.Pa.1975), 394 F.Supp. 22; *Pennsylvania Pharmaceutical Assn. v. Pa. Dept. of Pub. Welfare* (W.D.Pa.1982), 542 F.Supp. 1349. However, the courts below did not hold that Ohio Adm.Code 5101:3-2-20 violated a set minimum rate. The Court of Claims found that ODHS violated the statute by adopting the rule due to its own budgetary constraints and by failing to consider the rule's effect on efficiency, economy, and the quality of care.

The Medicaid statutes impose a duty on state programs to adequately reimburse their Medicaid providers. In interpreting Section 1396a(a)(13)(A) (the Boren Amendment),[3] the Supreme Court of the United States held that [101] "the Boren Amendment imposes a binding obligation on States participating in the Medicaid program to adopt reasonable and adequate rates ***." *Wilder v. Virginia Hosp. Assn.* (1990), 496 U.S. _____, at _____-_____, 110 S.Ct. 2510, at 2518-

[3] The Boren Amendment provides in pertinent part:

"(a) Contents.

"*** A State plan for medical assistance must—

"***

"(13) provide—

"(A) for payment *** of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State ***) *** which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access *** to inpatient hospital services of adequate quality ***." Section 1396a(a)(13)(A), Title 42, U.S.Code.

2519, 110 L.Ed.2d 455, at 468-469. The legislative history of the Boren Amendment indicates Congressional "intent that a State not develop rates under this section solely on the basis of budgetary appropriations ***." H.R.Conf.Rep. No. 96-1479, 9th Cong., 2d Sess. 154, reprinted in 1980 U.S.Code Cong. & Adm.News 5526, 5944.

Although *Wilder* involved a challenge to per-diem charges for inpatient care, the selfsame analysis applies to the outpatient fees involved in this case. In *Wilder* the Supreme Court based its interpretation of the Boren Amendment on a variety of factors which follow.

The court held that the language of the Amendment is mandatory rather than precatory, and that the receipt of federal funds is expressly conditioned on compliance with the Amendment. *Id.* at _____, 110 S.Ct. at 2519, 110 L.Ed.2d at 469. The Boren Amendment states that "the state plan '*must*' 'provide for payment *** of hospital(s)' according to rates the State finds are reasonable and adequate." *Id.* (quoting Section 1396a[a][13][A]). Section 1396a(a)(30)(A), as quoted *supra*, contains similar mandatory language.

Just as important, the court relied on the understanding between Congress and the states that the Medicaid Act granted enforceable rights to health care providers. *Id.* at _____-_____, 110 S.Ct. at 2521-2523, 110 L.Ed.2d at 471-473. The same reasons relied on by the United States Supreme Court in *Wilder* support a decision that ODHS violated Section 1396a(a)(30)(A) by basing its decision solely on budgetary concerns.

This court has applied *Wilder* to a suit challenging ODHS's decision to reduce the ceiling for administrative and general services cost reimbursement from $12.55 to

$10.80. *Ohio Academy of Nursing Homes, Inc. v. Barry* (1990), 56 Ohio St.3d 120, 564 N.E.2d 686. In *Barry*, we allowed Medicaid providers to sue in the court of common pleas for injunctive relief or a declaratory judgment under Section 1983, Title 42, U.S.Code. We also recog-[102]nized that Medicaid providers have a legitimate property interest in the reimbursement rate. Today's decision is a natural extension of that case.

Courts have invalidated a variety of rate cuts because the state did not make findings that its rates were reasonable and adequate. The United States Court of Appeals for the Tenth Circuit invalidated a plan where the state used a "budget adjustment factor" to divide its median cost of care in half. *AMISUB (PSL), Inc. v. Colorado Dept. of Social Services* (C.A.10, 1989), 879 F.2d 789, 796, certiorari denied (1990), 496 U.S. _____, 110 S.Ct. 3212, 110 L.Ed.2d 660 (applying Section 1396a[a][13][A]). Similarly, a federal district court enjoined Illinois from deferring 23.5 percent of its final hospital reimbursement, due to a budgetary crisis, because the plan failed to satisfy the federal requirement that Medicaid reimbursement rates be sufficient to ensure quality care. *Illinois Hosp. Assn. v. Illinois Dept. of Public Aid* (N.D.Ill.1983), 576 F.Supp. 360, 370, 372.

The trial court below found that Ohio Adm.Code 5101:3-2-20 was adopted solely for budgetary reasons without due consideration of its effect on the quality of care. We defer to that finding of fact as it is amply supported by the record. Accordingly, we hold that former Ohio Adm.Code 5101:3-2-20 violates Title XIX of the Social Security Act, Section 1396a(a)(30)(A), Title 42, U.S.Code, because it was implemented solely for budgetary reasons, without consideration of its effect on the quality of care provided by the Medicaid program.

II

The next issue presented is whether a violation of the federal Medicaid statute also violates state law. ODHS asserts that the state is not liable to the hospitals under former R.C. 5111.02(D) (subsequently renumbered as 5111.012, without amendment). The department relies for authority on a series of cases which hold that statutory duties owed by the government to the general public may not be the basis of monetary liability to an individual suing for the breach of that duty. *Sawicki v. Ottawa Hills* (1988), 37 Ohio St.3d 222, 525 N.E.2d 468; *Commerce & Industry Ins. Co. v. Toledo* (1989), 45 Ohio St.3d 96, 543 N.E.2d 1188; *Williamson v. Pavlovich* (1989), 45 Ohio St.3d 179, 543 N.E.2d 1242. None of these authorities is applicable here. This case does not involve a general member of the public suing in tort for the violation of a statutory duty that benefits all members of the public. The authorities cited might apply if this were a tort suit brought by a patient alleging that the administrative rule caused diminished access to medical care and a resulting injury. However, these authorities have no bearing on a suit brought by a Medicaid provider challenging the reimbursement rate. The [103] provider has a direct interest in its reimbursement rate, which surpasses the broad, generalized interests raised in *Sawicki* and its progeny.

Former R.C. 5111.02(D) provided that:

"*** Expenditures for medical assistance shall be made from funds appropriated to the department of human services for public assistance subsidies. The program shall conform to the requirements of the 'Social Security Act,' 49 Stat. 620 (1935), 42 U.S.C. 301, as amended."

Today, we hold that former R.C. 5111.02(D) incorporates the requirements of the Social Security Act, and former Ohio Adm.Code 5101:3-2-20 also violates state law because it does not meet the requirements of the Medicaid statute.

III

Notwithstanding its violation of federal and state law, ODHS asserts that the state is immune from money damages for the promulgation of invalid administrative rules. Appellant urges that because administrative rules could be challenged in the court of common pleas prior to the enactment of the Court of Claims Act, this suit does not fall within the waiver of sovereign immunity granted by R.C. 2743.02(A)(1). The Court of Claims Act waives sovereign immunity and establishes the Court of Claims, but also states, "[t]o the extent that the state has previously consented to be sued, this chapter has no applicability." R.C. 2743.02(A)(1). Appellant is essentially challenging the jurisdiction of the Court of Claims over this matter and claiming that the state has not waived its immunity from liability for money damages that result from an invalid administrative rule.

The Court of Claims has jurisdiction over this action pursuant to R.C. 2743.02 and 2743.03. "A major purpose of the Court of Claims Act was to centralize the filing and adjudication of all claims against the state. The Court of Claims was created to become the sole trial-level adjudicator of claims against the state, with the narrow exception that specific types of suits that the state subjected itself [to] prior to 1975 could be tried elsewhere as if the defendant was a private party." *Friedman v. Johnson* (1985), 18 Ohio St.3d 85, 87, 18 OBR 122, 124, 480 N.E.2d 82, 84. The Court of Claims has exclusive,

original jurisdiction in all civil suits for money damages even where ancillary relief such as an injunction or declaratory judgment is sought. *Friedman, supra.* However, a suit that seeks only injunctive or declaratory relief may be brought against the state in the court of common pleas. *Racing* [104] *Guild of Ohio, Local 304 v. State Racing Comm.* (1986), 23 Ohic St.3d 317, 320, 28 OBR 386, 388-389, 503 N.E.2d 1025, 1028.[4]

We hold that this suit is within the jurisdiction of the Court of Claims because of the nature of the claims raised and the relief sought. The hospitals initially sought relief for violations of their provider agreements and an earlier settlement agreement between certain of the parties, as well as for violations of federal law, state law, the United States Constitution, and the Ohio Constitution. The complaint sought declaratory, injunctive, and monetary relief. The claims for violation of the provider agreements and an earlier settlement agreement are within the exclusive jurisdiction of the Court of Claims to the extent that the hospitals allege that their contractual rights have been violated and seek monetary relief. R.C. 2743.02 and 2743.03. The Court of

[4] It is interesting to note that after the commencement of this suit, the General Assembly clarified its intent in an amendment to R.C. 2743.03.

R.C. 2743.03(A)(2) currently provides:

"If the claimant in a civil action as described in division (A)(1) of this section also files a claim for a declaratory judgment, injunctive relief, or other equitable relief against the state that arises out of the same circumstances that gave rise to the civil action described in division (A)(1) of this section, the court of claims has exclusive, original jurisdiction to hear and determine that claim in that civil action. This division does not affect, and shall not be construed as affecting, the original jurisdiction of another court of this state to hear and determine a civil action in which the *sole* relief that the claimant seeks against the state is a declaratory judgment, injunctive relief or other equitable relief." (Emphasis added.)

Claims actually found that the provider agreements had been violated under state contract law, but the court of appeals held that this determination was harmless error.

Appellant also raises the applicability of R.C. 2743.02 to challenge the court's order that ODHS reimburse all affected hospitals for all monies withheld under the budget reductions. Appellant relies on *Reynolds v. State* (1984), 14 Ohio St.3d 68, 14 OBR 506, 471 N.E.2d 776, to demonstrate that the waiver of immunity granted by R.C. 2743.02 does not apply to the promulgation of invalid administrative rules. ODHS argues that rule-making is the product of highly discretionary policymaking and also relies on the language in R.C. 2743.02(A)(1) which provides that liability be determined "in accordance with the same rules of law applicable to suits between private parties ***." According to appellant, this language demonstrates that immunity to monetary damages is waived only for private causes of action (such as tort and contract).

However, sovereign immunity is not applicable to the relief granted in this case. The order to reimburse Medicaid providers for the amounts unlawfully withheld is not an award of money damages, but equitable relief. The [105] distinction between tort damages and money claimed through specific performance of a legal duty was recently addressed by the United States Supreme Court in *Bowen v. Massachusetts* (1988), 487 U.S. 879, 108 S.Ct. 2722, 101 L.Ed.2d 749. *Bowen* involved a state suit against the federal government for Medicaid monies due under federal law. The court quoted extensively from Judge Bork's opinion in *Maryland Dept. of Human Resources v. Dept. of Health & Human Services* (C.A.D.C. 1985), 763 F.2d 1441:

" '*** Damages are given to the plaintiff to *substitute* for a suffered loss, whereas specific remedies "are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled." D. Dobbs, *Handbook on the Law of Remedies* 135 (1973). Thus, while in many instances an award of money is an award of damages, "[o]ccasionally a money award is also a specie remedy." *Id.* ***

" 'In the present case, Maryland is seeking funds to which a statute allegedly entitles it, rather than money in compensation for the losses, whatever they may be, that Maryland will suffer or has suffered by virtue of the withholding of those funds. If the program in this case involved in-kind benefits this would be altogether evident. The fact that in the present case it is money rather than in-kind benefits that pass from the federal government to the states (and then, in the form of services, to program beneficiaries) cannot transform the nature of the relief sought—specific relief, not relief in the form of damages.***' " (citation omitted; emphasis *sic*.) *Bowen, supra*, 487 U.S. at 895, 108 S.Ct. at 2732-2733, 101 L.Ed.2d at 764-765.

We find this distinction applicable to this suit. The reimbursement of monies withheld pursuant to an invalid administrative rule is equitable relief, not money damages, and is consequently not barred by sovereign immunity.

IV

Finally, ODHS challenges the court of appeals' determination that although a Section 1983 action cannot be brought in the Court of Claims, the hospitals are entitled to raise their constitutional claims directly under the Fourteenth Amendment. Because we find that the hospitals are entitled to relief under Section 1396a(a)(30)(A), Title 42, U.S.Code, and former R.C. 5111.02(D), we need not address this alternate basis for relief. "No court should *** indulge the constitutional issue if the litigant is entitled to relief upon other grounds." *Burt Realty Corp. v. Columbus* (1970), 21 Ohio St.2d 265, 269, 50 O.O.2d 491, 493, 257 N.E.2d 355, 358; *Greenhills Home Owners Corp. v. Greenhills* (1966), 5 Ohio St.2d 207, 34 O.O.2d 420, 215 N.E.2d 403.

[106] For the foregoing reasons, we affirm the judgment of the court of appeals and we vacate, as moot, the portion of the court's decision that addresses the constitutionality of former Ohio Adm.Code 5101:3-2-20.

Judgment affirmed.

MOYER, *C.J.*, SWEENEY, HOLMES, H. BROWN and RESNICK, *JJ.*, concur.

DOUGLAS, *J.*, concurs in judgment only.

OPINION OF THE COURT OF APPEALS, TENTH APPELLATE DISTRICT, FRANKLIN COUNTY, OHIO

(Rendered June 21, 1990)

No. 88AP-1034

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

OHIO HOSPITAL ASSOCIATION, *et al.*,
Plaintiffs-Appellees,
(Cross-Appellants),

v.

THE OHIO DEPARTMENT OF HUMAN SERVICES,
Defendant-Appellant,
(Cross-Appellee).

OPINION

BRICKER & ECKLER, MR. JAMES J. HUGHES, JR., MS. DIANE M. SIGNORACCI, and MS. ELISABETH A. SQUEGLIA, for appellees (cross-appellants).

MR. ANTHONY J. CELEBREZZE, JR., Attorney General, GURLEY, RISHEL, MYERS & KOPECH, MR. JAMES R. RISHEL and MR. DAVID E. NORTHROP, Special Counsel, for appellant (cross-appellee).

APPEAL from the Ohio Court of Claims.

WHITESIDE, *J.*

Defendant, State of Ohio, acting through its Department of Human Services ("ODHS"), appeals from a judgment of the Ohio Court of Claims granting judgment in favor of plaintiffs, Ohio Hospital Association and various hospitals, on their claim for injunctive, declaratory, and monetary relief filed in response to the implementation of Ohio Adm. Code 5101:3-2-20. Plaintiffs also filed a cross-appeal. Sixteen assignments of error are raised by defendant ODHS, as follows:

[2] "I. Argument in support of the first assignment of error: the trial court erred in holding that the subject matter of this suit is not within the state's sovereign immunity.

"II. Argument in support of the second assignment of error: the trial court erred in holding that the hospitals may sue directly on the Social Security Act, and therefore need not invoke the authority to sue conferred by 42 U.S.C. Section 1983.

"III. Argument in support of the third assignment of error: the trial court erred in holding that the hospitals may sue directly on the Fourteenth Amendment of the United States Constitution, and therefore need not invoke the authority to sue conferred by 42 U.S.C. Section 1983.

"IV. Argument in support of the fourth assignment of error: the trial court erred in holding that the hospitals may sue directly on the supremacy clause of Article VI of the United States Constitution, and therefore need not invoke the authority to sue conferred by 42 U.S.C. Section 1983.

"V. Argument in support of the fifth assignment of error: the trial court erred in holding that 42 U.S.C. Section 1396a(a)(13)(A), the 'Boren Amendment,' applies to Medicaid rates for the provision of hospital outpatient services.

"VI. Argument in support of the sixth assignment of error: the trial court erred in holding that 42 U.S.C. Section 1396a(a)(30)(A) requires that Medicaid rates for the provision of hospital outpatient services at a minimum pay the hospital 100% of the reasonable cost of providing the service.

"VII. Argument in support of the seventh assignment of error: the trial court in holding that 42 U.S.C. Section 1396a(a)(2) requires that Medicaid rates for the provision of hospital outpatient services at a minimum pay the hospital 100% of the reasonable cost of providing the service.

"VIII. Argument in support of the eighth assignment of error: the trial court erred in holding that the hospitals have standing to challenge OAC 5101:3-2-20 as violative of 42 CFR Section 447.204.

[3] "IX. Argument in support of the ninth assignment of error: the trial court erred in holding that 42 CFR Section 447.204 requires that Medicaid rates for the provision of hospital outpatient services at a minimum pay the hospital 100% of the reasonable cost of providing the service.

"X. Argument in support of the tenth assignment of error: the trial court erred in holding that 42 U.S.C. Section 1395x(v)(1)(A) requires that Medicaid rates for the provision of hospital outpatient services at a minimum pay 100% of the reasonable cost of providing that service.

"XI. Argument in support of the eleventh assignment of error: the trial court erred in holding that a Medicaid rate for the provision of outpatient

hospital services is unlawful as arbitrary and unreasonable if the rate does not pay 100% of the reasonable cost of providing the service.

"XII. Argument in support of the twelfth assignment of error: the trial court erred in holding that the second adoption of OAC 5101:3-2-20 as an emergency rule contravened section 119.03(F), Revised Code, by extending beyond ninety days of the first adoption of the rule as an emergency rule.

"XIII. Argument in support of the thirteenth assignment of error: the trial court erred in holding that a money judgment may be imposed against DHS for violation of Section 119.03(F), Revised Code.

"XIV. Argument in support of the fourteenth assignment of error: the trial court erred in holding that OAC 5101:3-2-20 deprives the hospitals of property without just compensation.

"XV. Argument in support of the fifteenth assignment of error: the trial court erred in holding that OAC 5101:3-2-20 deprives the hospitals of equal protection of the laws.

"XVI. Argument in support of the sixteenth assignment of error: the trial court erred in holding that OAC 5101:3-2-20 breaches the provider agreements between DHS and the hospitals."

[4] By way of cross-appeal, plaintiffs set forth the following two assignments of error:

1. "The plaintiffs-cross-appellants established a right to relief against the defendant-cross-appellee under 42 U.S.C. Section 1983 for the promulgation and application of Ohio Adm. Code Section 5101:3-2-20, and are therefore, entitled to attorney fees pursuant to 42 U.S.C. Section 1988."

2. "The promulgation and application of Ohio Adm. Code Section 5101:3-2-20 by the defendant-cross-appellee breached the settlement agreement

> dated April 4, 1983 between the defendant-cross-appellee and various of the plaintiffs-cross-appellants."

Plaintiffs include organizations whose membership consists of various hospitals which provide assistance to eligible Medicaid recipients, as well as individual hospitals which provide the same assistance. Medicaid assistance is provided to qualified recipients pursuant to R.C. Chapter 5111, wherein Ohio has statutorily enacted its participation in the federal Medicaid program, Section 1396, Title 42, U.S. Code, *et seq.*, and has designated ODHS to administer the Medicaid program. Hospitals participate through provider agreements entered into with ODHS.

Prior to January 4, 1988, ODHS reimbursed participating hospitals for outpatient services under a "cost-based reimbursement" method, which entailed reimbursing each hospital for the costs of the resources directly and indirectly utilized in providing health care services.[1] On the above-mentioned date, ODHS adopted Ohio Adm. Code [5] 5101:3-2-20 as an emergency rule having immediate effect. Ohio Adm. Code 5101:3-2-20, as adopted on January 4, 1988, stated in pertinent part:

> "Effective with the date of this rule, payments for outpatient hospital services reimbursed on a cost-related basis will be limited to the lesser of eighty-eight per cent of reasonable costs *** or eighty-eight per cent of billed charges for services

[1] ODHS (then the Ohio Department of Public Welfare), implemented emergency rules on March 4, 1983, adopting a prospective method of payment of hospital outpatient services. The ensuing challenge to the emergency rules and the settlement agreement which resulted in repeal of the rules (*Children's Hospital v. Cuddy*, Franklin County Common Pleas, Case No. 83CV-03-1416), are the basis for count 10 of plaintiffs' amended complaint, as well as the second assignment of error of the cross-appeal.

> furnished to eligible recipients. Effective July 1, 1988, the percent described in this paragraph is revised from eighty-eight to ninety-two. Services reimbursed on a cost-related basis which are subject to the provisions of this rule include all covered outpatient hospital services except *** [certain defined] services ***."

The rule was readopted as an emergency rule on March 31, 1988, and on April 13, 1988, Ohio Adm. Code 5101:3-2-20 was adopted as a permanent rule by ODHS.[2] Contemplating a relatively short time period during which the "88/92 percent cost methodology" would be utilized, presumably eighteen months, ODHS concluded that the anticipated reduced revenue of .2 percent of the total cost of the hospitals which provided outpatient services to Medicaid patients constituted a minor impact which could be withstood by the affected hospitals.

Plaintiffs commenced this action against ODHS on April 27, 1988, seeking injunctive, declaratory, and monetary relief.[3] In ten counts, plaintiffs alleged, *inter alia*, that Ohio Adm. Code 5101:3-2-20 violated several provisions of the United States Constitution, federal law [6] and Ohio law. Plaintiffs' motion for a temporary restraining order and the motion to dismiss filed by ODHS were overruled by the trial court, and the case subsequently proceeded to trial only on the issue of liability in counts one through nine. A separate trial on

[2] Ohio Adm. Code 5101:3-2-20 was amended, effective July 1, 1989; the new section adopted a prospective method of payment and repealed the former "88/92 percent cost methodology" system adopted on April 13, 1988.

[3] Also named as defendants were the State of Ohio and Patricia Barry, Director of ODHS, but Barry was dismissed by the Court of Claims and the State of Ohio was deleted from the caption as surplusage. Pursuant to R.C. 2732.02(E), the state should be the named defendant, although the state agency involved must be named. See, also, *Scott v. Ohio Dept. of Taxation* (1983), 11 Ohio App. 3d 20.

the issues raised in count ten was held at a later date, at the close of which the trial court ruled from the bench in favor of ODHS.

The trial court subsequently rendered its decision in favor of plaintiffs on counts one through nine. A judgment entry was filed, from which ODHS timely filed the instant appeal.

In its first assignment of error, ODHS contends that the state's sovereign immunity shields ODHS from this action. This claim was also the basis of the motion to dismiss filed by ODHS, which was overruled without discussion by the trial court. Essentially, ODHS argues that the adoption of Ohio Adm. Code 5101:3-2-20 falls outside of the immunity previously enjoyed by the state but waived in certain instances upon creation of the Court of Claims, R.C. 2743, *et seq.*, and that the Court of Claims thus lacks subject-matter jurisdiction over the case.

Ohio waived its statutory immunity in R.C. 2743.02 as part of the Court of Claims Act. R.C. 2743.02 states in pertinent part:

> "The state hereby waives its immunity from liability and consents to be sued, and have its liability determined, in the court of claims created in this chapter in accordance with the same rules of law applicable to suits between private parties ***. To the extent that the state has previously consented to be sued, this chapter has no applicability."

The foregoing language was interpreted by the Supreme Court of Ohio in *Reynolds v. State* (1984), 14 Ohio St. 3d 68, paragraph one of the syllabus, [7] as meaning "that the state cannot be sued for its legislative or judicial functions or the exercise of an executive or planning

function involving the making of a basic policy decision which is characterized by the exercise of a high degree of official judgment or discretion."

ODHS argues that the adoption of Ohio Adm. Code 5101:3-2-20 required a "high degree of official judgment or discretion," as well as the exercise of the state's legislative function, as defined in *Reynolds, supra*, which thus cloaked the state with immunity. ODHS also cites several cases applying *Reynolds* and argues that, given the narrower scope of the governmental decisions which were held to be immune from suit in those cases, the implementation of the disputed rule in this case which involved legislative policy-making clearly comes within the state's retained sovereign immunity.

We agree that the *act of promulgating* the rule is immune from liability as an executive or legislative action. However, it does not necessarily follow from that proposition that the rule itself is exempt from challenge. Assuming that ODHS's contention were correct, then no state agency could ever be held accountable for enforcing invalid rules since rule-making necessarily encompasses executive or legislative action, a result surely not intended by the doctrine of sovereign immunity. The issue of the validity or applicability of a rule has always been a proper issue for a court to decide, apart from the question of immunity. The remedy of declaratory judgment testing the constitutionality, validity, or construction is an available remedy notwithstanding sovereign immunity. Prior to the enactment of R.C. 2743.02, the state itself could not be sued [8] even in declaratory judgment, but an officer of the state could be sued in declaratory judgment to test whether that officer was properly performing his duties for the state with

such an action not being considered one against the state itself. See *State, ex rel. Ferguson, v. Shoemaker* (1975), 45 Ohio App. 2d 83.

Moreover, *Reynolds* further held that "*** once the decision has been made to engage in a certain activity or function, the state may be held liable, in the same manner as private parties, for the negligence of the actions of its employees and agents in the performance of such activities." *Reynolds*, therefore, recognizes that, although the initial decision to act may be immune from attack, collateral actions relating to that decision may subject the state to liability. In this case, although the actual decision by ODHS to reduce the rate of Medicaid reimbursement paid to provider hospitals for outpatient services arguably may have involved the type of official judgment held in *Reynolds* to be immune from suit, implementation of that decision and the concomitant actions taken in furtherance of promulgating the disputed rule do not enjoy the same immunity. *Cf. Bowers v. Ohio Dept. of Natural Resources* (1986), 34 Ohio App. 3d 347, dissenting opinion by Judge Handwork, at 350.

In other words, although no liability can attach merely as a result of promulgating the rule, the effect of execution of the rule, if invalid, may give rise to liability of the state if a state officer or employees acting on behalf of the state uses such an invalid rule to refuse to make payments in the full amount mandated by law. An action against the state for the unpaid balance is proper since the state is required [9] by law to make the proper payment. Accordingly, the first assignment of error is overruled.

We next address ODHS's second, fifth, sixth, seventh, eighth, ninth, tenth and eleventh assignments of error and plaintiffs' first cross-assignment of error, all of which discuss federal law causes of action. Four issues are raised by the assignments of error: (1) whether plaintiffs' claims were properly brought under Section 1983, Title 42, U.S. Code ("Section 1983"); (2) whether the claims were permissible as arising directly under the provisions of the Social Security Act; (3) whether certain provisions of the Social Security Act and/or the rules promulgated thereunder apply in this case; and (4) whether the enumerated provisions require ODHS to reimburse provider hospitals for one hundred percent of the reasonable costs incurred in providing outpatient services.

The first issue was recently addressed by the United States Supreme Court in *Will v. Michigan Dept. of State Police* (1989), 109 S.Ct. 2304, 105 L.Ed. 2d 45. In *Will*, suit was brought in state court against the Department of State Police and the Director of State Police by Will, an employee of the department who alleged that the state's denial of his promotion violated his rights under the United States and Michigan Constitutions. The suit was filed under Section 1983, which provides as follows:

> "Every *person* who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the [10] Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of

> Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia." Section 1983, Title 42, U.S. Code. (Emphasis added.)

The Supreme Court in *Will* concluded that neither the state nor a state official acting in his or her official capacity is a person within the meaning of Section 1983. The court determined, although "Section 1983 provides a federal forum to remedy many deprivations of civil liberties, *** it does not provide a federal forum for litigants who seek a remedy against a *State* for alleged deprivation of civil liberties." *Will*, at 2309 (emphasis added). The court rejected the plaintiff's argument that the legislative history of Section 1983 suggests a different result and held further, as follows:

> "Construing §1983 as a remedy for 'official violation of federally protected rights' does no more than confirm that the section is directed against state action—action 'under color of' state law. It does not suggest that the State itself was a person that Congress intended to be subject to liability." *Will*, at 2310.

This court previously held that a Section 1983 lawsuit may not be brought against the state of Ohio in a state court. *Kinney v. Ohio Dept. of Admin. Serv.* (1986), 30 Ohio App. 3d 121, 122. See, also, *Burkey v. Southern Ohio Correctional Facility* (1988), 38 Ohio St. 3d 170, the syllabus of which holds "[s]tates and state agencies are not 'persons' within the meaning of Section 1983, Title 42, U.S. Code".

Plaintiffs having chosen to bring suit in the Court of Claims, and the state of Ohio being the only proper defendant in the Court of Claims, it follows that, insofar as this action was brought against ODHS [11] under Section 1983, it was not proper. Accordingly, the trial

court did not err in failing to recognize plaintiffs' causes of action under Section 1983.[4] Logically, then, plaintiffs were not entitled to attorney fees under Section 1983.[5]

The second issue raised by the assignments of error addressing ODHS's federal law causes of action is whether, given the unavailability of Section 1983, the trial court erred in holding that plaintiffs were able to assert their federal law claims directly under Title XIX of the Social Security Act (SSA).

Although ODHS cites several cases, including a recent case from this court, *The Ohio Academy of Nursing Homes, v. Barry* (June 22, 1989), Case No. 89AP-826, unreported (1989 Opinions 2254), to support its position that no private right of action exists under the SSA, we do not need to reach that issue. Plaintiffs essentially contend that Ohio Adm. Code 5101:3-2-20 violates *state* law, not federal law. Specifically, R.C. 5111.02(D) states, in pertinent part, that:

> "The county department of human services of each county shall establish the eligibility for medical [12] assistance of persons living in the county, and shall notify the department of human services in the manner prescribed by the department. The county shall be reimbursed for administrative expenditures

[4] Plaintiffs assert in their response to ODHS's motion to file *Will* as additional case authority that in none of its assignments of error does ODHS specifically argue that the trial court erroneously considered ODHS to be a "person" for purposes of Section 1983 and that *Will* is, thus, inapposite to this case. However, we look to the substance of the assignments of error advanced by ODHS, as well as plaintiffs' first cross-assignment of error, not merely the wording of the errors assigned, and it is apparent that the appropriateness of a Section 1983 claim in this case is at issue.

[5] The Court of Claims determined that plaintiffs were not entitled to attorney fees under the authority of *Drain v. Kosydar* (July 31, 1979), Case No. 79AP-778, unreported (1979 Opinions 2167), wherein this court held that the Court of Claims erred in awarding attorney fees.

> in accordance with sections 5101.16 and 5101.161 [5101.16.1] of the Revised Code. Expenditures for medical assistance shall be made from funds appropriated to the department of human services for public assistance subsidies. The program shall conform to the requirements of the 'Social Security Act,' 49 Stat. 620 (1935), 42 U.S.C. 301, as amended."

State law thus requires that a medical assistance program conform to the requirements of the Social Security Act and, in effect, incorporates the SSA into the state statute. Accordingly, although we must refer to federal law to determine if Ohio Adm. Code 5101:3-2-20 conforms with R.C. 5111.02(D), nonconformity would constitute a violation of state law, namely, R.C. 5111.02(D). As such, even if the trial court erred in holding that plaintiffs could assert their claims directly under Title XIX of the SSA, any error is not prejudicial as the result is the same under state law, which in effect incorporates the SSA.

The third and fourth issues we address relative to the causes of action based upon federal law are first, whether certain enumerated provisions of the SSA are applicable here, and, second, if applicable, whether ODHS followed them in enacting Ohio Adm. Code 5101:3-2-20. We turn first to Section 1396(a)(30)(A), Title 42, U.S. Code, which requires state Medicaid programs to provide:

> "*** such methods and procedures relating to the *** payment for, care and services available under the plan *** and to assure that payments are consistent with efficiency, economy, and quality of care ***.

In its seventh conclusion of law, the trial court determined in part that:

> [13] "Under defendant's current cost reimbursement principles a hospital can recover from the Medicaid program only those costs determined by Medicare *** to be both reasonable and necessary in rendering outpatient services. [Citation omitted.] The percentage of cost reductions imposed by defendant pursuant to Ohio Adm. Code 5101:3-2-20 denies payment of 12 percent (8 percent after July 1, 1988) of the costs already determined by defendant to be reasonable and necessary to the delivery of services to Medicaid patients."

The trial court further held that, contrary to the "efficiency, economy, and quality of care" required by Section 1396(a)(30)(A), ODHS implemented Ohio Adm. Code 5101:3-2-20 strictly as a budgetary measure, and that the evidence established that the quality of care provided to Medicaid patients will decline if hospitals which are efficiently and economically operated are not permitted to recover the costs necessarily incurred in providing outpatient services.

ODHS does not dispute the applicability of Section 1396(a)(30)(A) to this action. However, ODHS interprets the trial court's decision as requiring hospitals to be reimbursed one hundred percent of the costs they have incurred in providing outpatient services to Medicaid patients. Basically, ODHS challenges the manifest weight of the evidence. Thus, if there is competent, credible evidence to support the judgment, reversal is not warranted. *C.E. Morris Co. v. Foley Construction Co.* (1978), 54 Ohio St. 2d 279.

We cannot agree with the interpretation advanced by ODHS. It is clear from the trial court's decision that the issue was not whether hospitals were reimbursed at a

minimum rate but, rather, whether ODHS complied with federally mandated standards in enacting Ohio Adm. Code 5101:3-2-20. The decision is replete with references to efficiency, [14] economy, and quality of care, and the concomitant failure of ODHS to consider these standards. (Trial court findings of fact 29, 33, 35, and 43 and conclusions of law 7 and 11).

Further, a review of the voluminous record and transcript supports the trial court's conclusions. Patricia Barry, Director of ODHS, testified that, as part of the state's budget reduction plans for 1988, ODHS determined to change the current method of payment to hospitals for providing outpatient services to Medicaid patients from the reasonable-costs method to a prospective-payment method. An estimated twelve million dollars was projected to be saved by the state under the new method, and these savings were incorporated into the budget request which was adopted by the legislature. However, the new method of reimbursement was not implemented at the beginning of the budget year and, consequently, to attempt to meet part of the projected savings, ODHS promulgated Ohio Adm. Code 5101:3-2-20. Barry testified that, prior to implementation of the rule, an impact analysis was undertaken by her staff to determine the impact of the twelve/eight percent cuts on the affected hospitals' overall operating budgets.

Paul Offner, the ODHS Assistant Deputy Director of Benefits Administration, testified that the outpatient cuts were made for two reasons: first, to aid in balancing the state's budget and, second, to attempt to allieviate the disparities in outpatient costs between a hospital setting and a physician's office setting. Offner testified that the cuts would have "no appreciable effect" on the

quality of care rendered to Medicaid patients. Offner's assistant, Kathy Glynn, also opined that the cuts would have no effect on the quality of care. However, she agreed that [15] the focus of the impact analysis conducted by ODHS was on the hospitals' total operating budget, rather than on efficiency, economy, and quality of care.

In sum, there is a dearth of evidence to suggest that ODHS applied the standard of Section 1396(a)(30)(A), Title 42, U.S. Code, prior to implementing Ohio Adm. Code 5101:3-2-20. Although ODHS introduced numerous exhibits illustrating studies and research undertaken prior to implementation of the new scheme, the majority of the research appears to be directed toward justifying ODHS's decision to alter outpatient reimbursement from cost-based to prospective and not its decision to make across-the-board cuts in actual outpatient reimbursement to hospitals by first twelve percent and then eight percent without regard to either the reasonable-costs or prospective-payment method. Mere unsupported assertions by ODHS staff members that the cuts will have no effect on the quality of care provided to Medicaid patients do not mandate reversal of the trial court on this issue. The trial court is the judge of credibility and was not required to accept these unsupported opinions expressed by ODHS staff members. Therefore, the trial court's finding that ODHS failed to comply with Section 1396(a)(30)(A), Title 42, U.S. Code, is fully supported by the record.

The other provisions of federal law disputed by ODHS as being applicable and/or violated include Section 1396(a)(13)(A), Title 42, U.S. Code (the Boren Amendment), Sections 1396(a)(2) and 1395x(v)(1)(A), Title 42, U.S. Code, and Section 447.204, Title 42, C.F.R.

Given our discussion above of Section 1396(a)(30)(A), it is clear that, in enacting Ohio Adm. Code 5111:3-2-20, ODHS also failed to comply with any of the standards [16] enunciated by those provisions. Even assuming, nonetheless, that the trial court erred in determing that one or all of the provisions applies under these facts, any error is nonprejudicial in light of our holding as to Section 1396(a)(30)(A). Accordingly, assignments of error numbers two, five, six, seven, eight, nine, ten, and eleven and plaintiffs' first cross-assignment of error are not well-taken.

We next address ODHS's constitutional claims as discussed in assignments of error three, four, fourteen, and fifteen. Plaintiffs alleged, and the trial court found, that the enactment of Ohio Adm. Code 5101:3-2-20 violated plaintiffs' due process and equal protection rights under the United States and Ohio Constitutions.

Preliminarily, ODHS challenges the trial court's holding that plaintiffs' constitutional claims were validly brought directly under the Fourteenth Amendment and Supremacy Clause of the United States Constitution. ODHS argues that plaintiffs' sole remedy was provided by Section 1983, Title 42, U.S. Code; that the state is not a person for purposes of Section 1983; and that plaintiffs' complaint on these counts should have been dismissed.

We agree, as discussed in reference to plaintiffs' federal law causes of action, that plaintiffs were foreclosed from asserting constitutional violations by the state in a Section 1983 action brought in the Court of Claims. *Will, supra*. However, ODHS cites no authority, and we are aware of none, which lends credence to ODHS's contention that allegations of constitutional

violations by a state's enactment of legislation cannot be brought directly under the Fourteenth Amendment. The argument is meritless.

[17] As to the merits of the constitutional claims, we find regarding the due process argument that the trial court erred in holding that Ohio Adm. Code 5101:3-2-20 violates plaintiffs' rights under the Fourteenth Amendment. The analysis utilized by the trial court appears to be based on substantive due process, which is not at issue here. *Cooperman v. Univ. Surgical Assoc., Inc.* (1987), 32 Ohio St. 3d 191. ODHS did not "take" plaintiffs' property (services) but instead refused to make statutorily mandated payments under the guise of adopting an invalid rule. However, even under a procedural due process analysis, plaintiffs have failed to allege or prove a constitutional violation. The constitutional right to procedural due process contemplates a meaningful opportunity for a claimant to be heard either prior to or after a deprivation has occurred. *Hudson v. Palmer* (1984), 468 U.S. 517; *Parratt v. Taylor* (1981), 451 U.S. 527, overruled in part on other grounds in *Daniels v. Williams* (1986), 474 U.S. 327; *Bd. of Regents v. Roth* (1972), 408 U.S. 564. Plaintiffs have demonstrated no manner in which they were deprived of this constitutional guarantee.

We likewise hold, contrary to the trial court's opinion, that plaintiffs' rights to equal protection were not impinged upon by the enactment of Ohio Adm. Code 5101:3-2-20. Plaintiffs contended that the singling out of hospitals from other providers of outpatient services unreasonably discriminated against hospitals in violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution and Article I, Section 2, of the Ohio Constitution.

There being no fundamental right nor suspect class at issue, the standard we apply is the traditional rational basis test, which [18] mandates that legislation "must be upheld against equal protection attack when the legislative means are rationally related to a legitimate governmental purpose." *Hodel v. Indiana* (1981), 452 U.S. 314, at 331; *Schweiker v. Wilson* (1981), 450 U.S. 221. Similarly, under the Ohio Constitution, classifications made by state legislations "*** 'must rest upon some ground of difference having a fair and substantial relation to the object of the legislation.' ***" *State, ex rel. Dayton Fraternal Order of Police Lodge No. 44, v. State Emp. Relations Bd.* (1986), 22 Ohio St. 3d 1, at 6, quoting *Allied Stores of Ohio, Inc. v. Bowers* (1959), 358 U.S. 522, 527. A presumption of constitutionality exists which can be overcome only by "a clear showing of arbitrariness and irrationality." *Hodel, supra.*

Within these parameters, Ohio Adm. Code 5101:3-2-20 violates no constitutional right to equal protection. Paul Offner testified during trial that reductions in reimbursement to hospitals for outpatient services were made for two reasons: (1) budgetary constraints, and (2) concern with substantial disparities between outpatient costs in hospitals and physician's offices. While the first reason may not adequately explain why only plaintiffs were affected, see, *e.g., The Ohio Academy of Nursing Homes, supra*, the second reason suffices. Coupling the state's legitimate interest in paring costs where necessary, with the demonstrated difference in costs between outpatient services provided in a hospital and outpatient services provided in a physician's office (see defendant's exhibit P), we find that the classification herein was rationally related to the object of the legislation.

[19] Thus, despite our holding that the trial court erred in regard to plaintiff's due process and equal protection claims, the errors were harmless in light of our conclusion of the federal-law claims, finding the rule to be in conflict and, thus, invalid. The problem here is not a rule unconstitutional under due process and equal protection standards but, instead, a rule invalid because it conflicts with the enabling state law, that is the federal law (SSA) adopted by state law.

Accordingly, the third, fourth, fourteenth, and fifteenth assignments of error are not well-taken.

By assignments of error numbers twelve and thirteen, ODHS argues that the trial court erred in finding: (1) that ODHS violated R.C. 119.03(F) when it readopted Ohio Adm. Code 5101:3-2-20 as an emergency rule prior to adopting it as a permanent rule, and (2) that plaintiffs were entitled to money damages as a result of the violation. The assignments of error are without merit. Insofar as we have determined that the rule is invalid because ODHS failed to comply with Section 1396(a)(30)(A), Title 42, U.S. Code, the question of whether ODHS's procedural noncompliance also invalidates Ohio Adm. Code 5101:3-2-20 becomes moot. Moreover, even were we to hold that the question is not moot, we find no error in the trial court's holding.

R.C. 119.03(F) states, in part, as follows:

"*** The emergency rule *** shall become invalid at the end of the ninetieth day it is in effect. Prior to that date the agency may adopt the emergency rule *** as a nonemergency rule *** by complying with the procedure prescribed by this section for the adoption *** of nonemergency rules. *The agency may not use the procedure of this division to readopt the emergency rule *** so that, upon the*

*emergency rule *** becoming invalid under this division, the emergency rule *** will* [20] *continue in effect without interruption for another ninety-day period ***.*" (Emphasis added.)

ODHS argues that, so long as the emergency rule is readopted prior to the ninety-day expiration of the adoption of the rule and exists as an emergency rule upon readoption for a period of less than ninety days, then readoption is proper.

We find no error in the trial court's holding that R.C. 119.03(F) does not permit the readoption of an emergency rule as a new emergency rule but only as a nonemergency permanent rule. Construing the legislative intent in such a manner is consistent with and required by statutory requirements for adopting nonemergency rules, including the requirements of notice and hearing. The clear language of R.C. 119.03(F) is that an emergency rule cannot be readopted as an emergency rule, and the attempted circumvention of this mandate was improper. The twelfth assignment of error is without merit.

ODHS next argues that plaintiffs were not entitled to monetary damages, even upon a finding that R.C. 119.03(F) was violated. Were that the basis for the award of money "damages," there might be merit to the contention. See *Metzger v. Superintendent of Building and Loan Assns.* (1986), 31 Ohio App. 3d 212, and *Sawicki v. Village of Ottawa Hills* (1988), 37 Ohio St. 3d 222, cited by ODHS. Plaintiffs, however, requested money damages only as recompense for the money they were wrongfully not paid due to the rate of reimbursement being unlawfully lowered, and there is no indication that the trial court intended to award anything different. No damages were awarded for the violation of R.C. 119.03(F).

Rather, the amount and measure of damages were agreed by the parties as being "the monetary amount by which Medicaid payments to hospitals for outpatient hospital services are reduced as the result of the [21] application of Ohio Administrative Code 5101:3-2-20," and such amounts were ordered paid although not specifically set forth. (See the trial court's entry of November 9, 1988.) Accordingly, the thirteenth assignment of error is without merit.

In the sixteenth assignment of error, ODHS argues that the trial court improperly held that ODHS breached the provider agreements between ODHS and the plaintiff-hospitals, citing as grounds the fact that no provider agreements were offered or admitted into evidence.

Although the trial court may have erred in finding that ODHS breached the "contracts" (provider agreements) with the hospitals, any error was harmless. Plaintiffs were not damaged due to a breach of contract but due to ODHS's failure to conform to the applicable law when setting the new rates, even though the agreements presumably required conformity with the SSA. See *State, ex rel. Montrie Nursing Home, Inc., v. Aggrey* (1978), 54 Ohio St. 2d 394; *The Ohio Academy of Nursing Homes, supra.* The sixteenth assignment of error is overruled.

Finally, in plaintiffs' second cross-assignment of error, it is contended that the trial court erred in failing to find that, in promulgating Ohio Adm. Code 5101:3-2-20, ODHS breached a settlement agreement entered in *Children's Hospital v. Cuddy,* cited *infra,* see footnote 1. Count ten of plaintiffs' second amended complaint, alleging violation of paragraph two of the settlement

agreement, was tried on August 11, 1988, separately from the other counts. The trial court ruled in favor of ODHS from the bench as to count ten on the grounds that the language of the disputed paragraph was ambiguous and that the judgment entry in the case reflected no intent on the part of ODHS to limit itself as to future changes in the reimbursement scheme. (Transcript 8/11/88, [22] pp. 129-131.) Such changes could be effected only by the adoption of a *valid* rule promulgated by compliance with statutory procedural requirements.

The disputed language, as set forth in a letter written to John Cuddy, former director of the Department of Public Welfare (now ODHS) and purportedly signed by Cuddy and Donald Newkirk, on behalf of the plaintiffs, reads as follows:

> "Hospitals shall be reimbursed for outpatient services in accordance with the rules which were in effect on March 3, 1983, until such time as a new method of reimbursement is established by appropriate rule-making." [Plaintiffs' exhibit 22.]

Plaintiffs contend that ODHS violated its agreement to reimburse hospitals under the former methodology until a "new method" was established, by its implementation of Ohio Adm. Code 5101:3-2-20, which was not a "new method" within the contemplation of the parties. Since, as we held *infra*, the rule attempted to be adopted is invalid, arguably ODHS violated the settlement, not by adopting an old method disguised as a new method, but by attempting to enforce an invalid rule.

Reading the language of the settlement agreement *in pari materia* with the language of the judgment entry, which states, in part, "nothing herein shall prevent the

proper amendment or revision of the aforesaid rules by the State of Ohio" (emphasis added), supports the contention that ODHS violated the agreement. Even though Ohio Adm. Code 5101:3-2-20 arguably was established in accordance with the rule-making procedures of R.C. Chapter 119, the rule is invalid because it improperly reduced payments. Since we have affirmed the trial court's finding that the rule is invalid, any error with respect to the holding as to the prior [23] settlement is not prejudicial since plaintiffs' relief does not vary. The second cross-assignment of error is overruled.

Accordingly, for the foregoing reasons, ODHS's sixteen assignments of error and plaintiffs' two cross-assignments of error are overruled, and the judgment of the Ohio Court of Claims is affirmed.

Judgment affirmed.

YOUNG and AMMER, *JJ.*, concur.

AMMER, *J.*, of the Pickaway County Court of Common Pleas, sitting by assignment in the Tenth Appellate District.

DECISION OF THE COURT OF CLAIMS

(Filed November 2, 1988)

Case No. 88-04961

IN THE COURT OF CLAIMS OF OHIO

OHIO HOSPITAL ASSOCIATION, *et al.*,
Plaintiffs,

v.

THE DEPARTMENT OF HUMAN SERVICES,
Defendant.

DECISION

FRED J. SHOEMAKER, *Judge*

This case came on for trial on a bifurcated basis with the sole issue for decision being that of liability, if any, of defendant. The evidence and arguments were completed and submitted for decision. Each party has filed proposed findings of fact and conclusions of law.

The court makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. The Ohio Hospital Association, The Greater Cleveland Hospital Association, and the Hospital Association of Central Ohio (collectively, "Plaintiff Associations"), on behalf of their respective hospital members ("Member Hospitals"); and Adams County Hospital, Bethesda Hospital, Inc., Brown County

General Hospital, Children's Hospital, Children's Hospital Medical Center, Children's Hospital Medical Center of Akron, Doctors Hospital, Doctors Hospital of Nelsonville, Fairview General Hospital, Meridia Health System, Riverside Hospital, [2] Saint Luke's Hospital Association, St. John Hospital, St. Joseph Hospital & Health Center, The Children's Medical Center, The Mt. Sinai Medical Center, and University Hospitals of Cleveland (collectively, "Plaintiff Hospitals") have brought this action against defendant Ohio Department of Human Services ("DHS") for injunctive, declaratory and monetary relief. The plaintiffs challenge defendant's implementation of Ohio Adm. Code 5101:3-2-20, to reduce the payment rates for outpatient hospital services delivered to Medicaid recipients, as arbitrary, unreasonable, in violation of relevant federal and state law and in breach of contract.

2. Ohio participates in the Medicaid program, a cooperative federal-state program established by Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.*, under which federal funds are provided to states to furnish necessary medical assistance to needy individuals. Pursuant to the present statutory formula, the mix of federal and state funds for Ohio's Medicaid program is 59 percent federal and 41 percent state.

3. DHS administers Ohio's Medicaid program pursuant to 42 U.S.C. §1396a(a)(5) and R.C. Chapter 5111. The Member Hospitals and Plaintiff Hospitals participate in Ohio's Medicaid program pursuant to their provider agreements with defendant, and provide outpatient services to Medicaid beneficiaries, in both the clinic and emergency room settings.

4. Hospitals that have accepted Public Health Service (Hill-Burton) funds for the construction of hospital facilities [3] are required by law to participate perpetually in the Medicaid program. 42 C.F.R. §124.503(c). The majority of the Member Hospitals and Plaintiff Hospitals are Hill-Burton hospitals and do not have the option of terminating their participation in the Medicaid program.

5. Among the methods by which hospitals may receive payment for outpatient services are the methods of payment of charges, cost-based reimbursement, and prospective payment. Under the charge-based payment method, a hospital is paid the fee established by the hospital for the services rendered. Under the cost-based reimbursement method, a hospital is reimbursed for the costs of the resources used directly and indirectly in providing health care services. Under the prospective payment method, a hospital is paid a fixed fee, usually established by the payor, for the services rendered. The court agrees that the prospective payment method best serves the public need for controlling spiraling Medicaid costs. The prospective payment method also encourages hospitals to efficiently and economically operate their facilites, while safeguarding against unnecessary utilization of care and services to Medicaid patients. In addition, the prospective payment method is consistent with efficiency, economy and quality of care.

6. Prior to March 4, 1983, defendant DHS reimbursed Ohio hospitals for the provision of both inpatient and outpatient [4] services to Medicaid patients under the cost-based reimbursement method. Ohio Adm. Code 5101:3-2-22. Defendant DHS has incorporated into Medicaid reimbursement the cost-based reimbursement standards and principles of the Medicare program. Ohio

Adm. Code 5101:3-2-22(C). Pursuant to those Medicare standards and principles, hospitals are reimbursed for the reasonable costs which are necessary in the efficient delivery of needed health services. 42 U.S.C. §1395x(v)(1)(A). In allocating and reporting these costs, hospitals are governed by extensive Medicare regulations and instructions. The costs reported by hospitals are then audited by Medicare and Medicaid auditors for compliance with Medicare and Medicaid regulations and instructions.

7. Am. Sub. H.B. 694, enacted by the 114th Ohio General Assembly for the biennium which began July 1, 1981 and ended June 30, 1983, directed DHS, then the Ohio Department of Public Welfare ("ODPW"), to develop and implement the prospective method of payment for hospital inpatient and outpatient services.

8. On March 4, 1983, defendant DHS implemented emergency rules, effective immediately under Executive Order 83-11, which replaced the cost reimbursement method of payment for hospital outpatient services with the prospective method of payment. Ohio Adm. Code 5101:3-1-60 (March 4, 1983).

9. On or about March 7, 1983, a number of plaintiffs in this action brought an action against John C. Cuddy, the Director of ODPW, and the Governor of Ohio to enjoin the implementation [5] and enforcement of the emergency rules as they related to hospital outpatient services. The action was styled *Children's Hospital, et al. v. John C. Cuddy, Director, Ohio Department of Public Welfare, et al.*, Case No. 83CV-03-1416. The parties settled the *Children's Hospital* case on April 4, 1983. Pursuant to the settlement, DHS repealed the emergency rules as they related to hospital outpatient services.

10. DHS reimbursed hospitals for outpatient services in accordance with the cost-based rules in effect on March 3, 1983 until January 4, 1988, with the exception of laboratory services, which were reimbursed on a fee-for-service basis beginning on October 1, 1984. Ohio Adm. Code 5101:3-2-43(A). Beginning on July 1, 1988, radiological diagnostic tests are reimbursed on a fee-for-service basis. Ohio Adm. Code 5101:3-2-21(E). The fee-for-service reimbursement of laboratory and radiology outpatient services is not the subject of this action.

11. Defendant DHS established a Medicaid Prospective Payment Task Force, which included industry representatives, to study and recommend a prospective payment system for hospital inpatient services. On October 1, 1984, defendant implemented a prospective payment system for hospital *inpatient* services. Ohio Adm. Code 5101:3-2-07 (1984). Pursuant to the prospective payment method, hospitals are paid a certain dollar amount for each hospital discharge based upon the primary diagnosis of the patient. (Emphasis added.)

12. In October, 1987, defendant DHS rebased the prospective [6] payment rates for hospital inpatient services by lowering the amount that is paid under the Medicaid program for inpatient hospital services and thereby decreasing hospital revenue from operations. Ohio Adm. Code 5101:3-2-074 (October 19, 1987).

13. On January 4, 1988, DHS adopted Ohio Adm. Code 5101:3-2-20 as an emergency rule having immediate effect. Ohio Adm. Code 5101:3-2-20 states, in pertinent part as follows:

> Effective with the date of this rule. Payments for outpatient hospital services reimbursed on a cost-related basis will be limited to the lesser of eighty-

eight percent of reasonable costs as such costs are described in paragraphs (B) and (C) to (C)(1)(f) of rule 5101:3-2-20 of the Administration Code or eighty-eight percent of billed charges for services furnished to eligible recipients.

14. On March 31, 1988, DHS adopted Ohio Adm. Code 5101:3-2-20 as an emergency rule having immediate effect.

15. On April 13, 1988, DHS adopted Ohio Adm. Code 5101:3-2-20 as a permanent rule, taking effect on April 23, 1988.

16. The events leading to the adoption of Ohio Adm. Code 5101:3-2-20 began in 1986, during DHS' preparation of the Medicaid budget for the budget biennium beginning July 1, 1987, and ending June 30, 1989. DHS decided upon a policy for reimbursement of hospital outpatient services for that biennium that included changing the reimbursement methodology from a retrospective 100 percent of cost basis to a prospective fee for service basis, and expending funds for such reimbursement at a [7] level of 10 percent less than what was projected to be spent under the 100 percent of cost basis.

17. There were three primary reasons for DHS' decision to change the reimbursement methodology for hospital outpatient services. First, the 100 percent cost reimbursement method provided no incentive to hospitals to minimize the costs, and provided an incentive for hospitals to exercise discretion to allocate costs to outpatient services and away from inpatient services that are reimbursed on a fixed payment basis. Second, to convert to a fee for service basis places hospitals on the same basis used for reimbursing physicians and other outpatient service providers,

thereby alleviating the large and growing disparity in the payment for services between provider groups. Third, placing hospitals on a fee for service basis encourages health care providers to increase the provision of outpatient services to Medicaid patients in more cost-effective settings and decrease the use of less cost-effective hospital facilities for the provision of such services.

18. In preparing the budget for the biennium ending June 30, 1989, DHS presumed that the fee for service reimbursement method for hospital outpatient services would be in place by October, 1987, and that method would incorporate the 10 percent reduction. The budget prepared and submitted to the Office of Budget and Management ("OBM") contained the 10 percent reduction. OBM in turn submitted a Medicaid budget containing [8] the 10 percent reduction to the General Assembly. The General Assembly was advised during the legislative process that the proposed budget incorporated the 10 percent reduction. The budget appropriation enacted by the General Assembly for the biennium ending June 30, 1989, incorporated the 10 percent reduction.

19. The budget assumption was that the starting date for initiation of the prospective fee system by DHS would be October 1987. It was not until January 4, 1988, halfway through the first year of the budget biennium, that the fee for service rule was proposed. As of that date, in order to meet the 10 percent reduction built into the budget, DHS would have had to impose a 17-20 percent reduction in hospital outpatient reimbursement for the remaining six months in fiscal year 1988. DHS' judgment was that that level of cut was too abrupt under the circumstances, and decided to impose a 12

percent reduction through promulgation of emergency rule Ohio Adm. Code 5101:3-2-20 while endeavoring to complete the process of adopting the fee for service rule.

20. The proposed fee for service rule encountered vigorous resistance by plaintiff Associations and member hospitals. As required by law, the proposed rule was submitted to the Joint Committee for Agency Rule Review ("JCARR") of the General Assembly, which was empowered to recommend that the General Assembly reject the rule and prevent its adoption. The hospital industry actively opposed the rule at JCARR. Senator Suhadolnik, Chairman of JCARR, telephoned Ms. Glynn at DHS, and informed her [9] that the rule would not be approved at JCARR due to hospital opposition, and requested that it be withdrawn. To retain good relations with JCARR, and to avoid forcing the members of JCARR to cast a vote on a controversial issue that the members desired not to vote on, and to avoid the one year mandatory waiting period for reproposing a rule that has been voted down by the General Assembly, DHS acceded to Senator Suhadolnik's request, and withdrew the proposed rule.

21. Given the inability to adopt a fee for service rule over opposition of the plaintiff Association and member hospitals, DHS, facing expiration of the emergency rule Ohio Adm. Code 5101:3-2-20, again adopted the rule on an emergency basis, and soon thereafter adopted it as a permanent rule.

22. All policy, rulemaking, and budget decisions of DHS were made by Director Barry in consultation with her staff.

23. The permanent version of Ohio Adm. Code 5101:3-2-20, effective April 23, 1988, was submitted to JCARR. JCARR did not recommend that the General

Assembly prevent the rule from becoming effective, nor did the Chairman of JCARR request that the rule be withdrawn, thereby acquiescing in the reduced reimbursement for hospital outpatient services.

24. The 88/92 percent of cost method embodied in Ohio Adm. Code 5101:3-2-20 was submitted to the Health Care Financing Administration of the DHS, and approved as part of the state medical assistance plan on April 20, 1988, with an [10] effective date of January 4, 1988.

25. The interim methodology embodied in OAC 5101-3-2-20 was intended to obtain some of the 10 percent reduction for hospital outpatient services which is incorporated in the present budget. It would not obtain all of the savings that would result from a 10 percent reduction. The 12 percent reduction for the period January 4, 1988, through June 30, 1988, constituted only a 6 percent reduction for the entirety of that fiscal year. The reduction for the fiscal year ending June 30, 1989, is 8 percent. Thus, if the growth in expenditures were as projected in 1986, the budget assumption of 10 percent would not be attained. Hospital outpatient reimbursement cost escalations are proving to be far greater than projected. These budget appropriations for hospital outpatient services are part of a total spending overrun in the Medicaid program now projected to be approximately 100 million dollars after exhaustion of the caseload contingency funds. No money has been appropriated by the General Assembly to meet this budget Medicaid deficiency.

26. Even with the 12 percent reduction in place since January 4, 1988, Medicaid expenditures for hospital outpatient services for fiscal year 1988 will exceed DHS' projection of expenditures in this fiscal year if there had been no reimbursement reduction.

27. DHS is presently gathering information uopn which to adopt a fee for service rule that meets many of the objections of [11] the Ohio hospital industry. The hospitals are required by rule Ohio Adm. Code 5101:3-2-21, adopted on April 23, 1988, to submit such information to DHS. The fee for service rule should be adopted as soon as DHS can evaluate the information and complete the drafting of the rule. The rule should be in place no later than July 1, 1989, as required by the General Assembly in Sub. H.B. 738, uncodified section 8(a). Accordingly, the 88 percent/92 percent of cost reimbursement methodology probably will be in place for no more than eighteen months.

28. Prior to imposing the reduced reimbursement embodied in Ohio Adm. Code 5101:3-2-20, DHS assessed whether the reduction would adversely impact the availability and quality of hospital outpatient care to Medicaid recipients, and concluded that there would be no adverse impact.

29. However, defendant DHS does not contend that the Medicaid cuts in reimbursement for hospital outpatient services were made in response to defendant's determination that Ohio hospitals were operating inefficiently. Defendant's Director Patricia Barry testified that DHS does not have the ability to distinguish an efficient hospital from an inefficient hospital.

30. Twenty-one thousand physicians in Ohio have agreements with DHS to provide services to Medicaid patients. Twenty-one hundred physicians responded to a recent survey by DHS and indicated that DHS may circulate their name as willing to treat Medicaid patients.

31. Physicians have a moral responsibility to provide [12] Medicaid patients with good medical care. By the same token, DHS has a responsibility to eliminate unnecessary red tape and see that physicians are paid promptly.

32. Prior to imposing the reduced reimbursement embodied in Ohio Adm. Code 5101:3-2-20, DHS assessed the financial impact upon the approximately 200 hospitals providing outpatient services to Medicaid patients. The analysis assumed a 10 percent reduction, and concluded that the reduced revenue would be .2 percent of the total cost of all hospitals of providing all services to all patients, and range from .1 percent to .9 percent for individual hospitals. DHS concluded that this impact was minor, and could be withstood by the hospitals for the short duration of the 88/92 percent of cost methodology. Because the actual reduction is 6 percent annualized over all fiscal year 1988, and 8 percent for fiscal year 1989, the actual impact will be less.

33. However, defendant DHS conducted no study or analysis prior to implementing either the emergency or permanent rule versions of Ohio Adm. Code 5101:3-2-20 to determine that the reduction in cost-based reimbursement was:

> a. reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities;
>
> b. consistent with efficiency, economy and quality of care;
>
> [13] c. adequate to assure availability of and access to Medicaid services;

d. adequate to assure that costs of Medicaid patients will not be borne by non-Medicaid patients.

34. DHS performed a study of the disparity of costs to the Medicaid program in the provision of outpatient services under the present system in which hospitals are reimbursed on a cost basis and other providers on a fee for service basis. The study concluded that the cost basis has produced wide variation among hospitals of the cost to the Medicaid program of providing the same service. The study further concluded that a large disparity exists within a hospital between an outpatient clinic and the emergency room. The study also concluded that a large disparity is present between services provided in a hospital clinic versus a physician's office. This study demonstrated that the present cost-based methodology provides no incentive to use the most cost-effective settings for the provision of outpatient services.

35. The court finds that the adoption of Ohio Adm. Code 5101:3-2-20 was based solely on the defendant's budgetary needs.

36. Otitis media (infection of the middle ear) is the most common condition paid for by Medicaid in an outpatient setting. The Medicaid payment for the facility fee (i.e., excluding the physician's fee) in an Ohio hospital is far greater than the payment to physicians in Ohio seeing patients in their offices and to hospital outpatient departments in Pennsylvania, Illinois, and Michigan, even after imposition of an 8 percent reduction to [14] Ohio hospitals.

37. There is a major disparity in the cost to the Medicaid program for the cost of a physician's office as opposed to a hospital as the facility in which outpatient

services are rendered. In June, 1987, the payment per recipient to physicians was $57.93, whereas payment per recipient to hospitals was $113.59.

38. The evidence proves that Medicaid recipients are not concerned about costs, but only about convenience. The Medicaid recipient is not paying any part of the fee. Therefore, the *least* cost-effective means of medical treatment is utilized most often by the Medicaid recipient. DHS could do something to require Medicaid recipients to use the most cost effective means of delivering medical services. Such medical recipients could be required to go to a private physician unless there is a medical need for hospital services. Such a state plan would substantially reduce spiraling Medicaid outpatient costs.

39. Ohio has over 200 hospitals that provide outpatient services to Medicaid recipients. The unreimbursed hospital outpatient service costs resulting from the Medicaid reductions of Ohio Adm. Code 5101:3-2-20 during the period from January 4, 1988 through June 30, 1989 is projected to total $16,600,000.

[15] 40. The Medicaid reductions in hospital outpatient reimbursement do not affect all hospitals similarly. Hospitals with high Medicaid outpatient utilizations, such as teaching hospitals, children's hospitals and hospitals located in poverty areas, absorb the majority of the Medicaid reductions and will suffer significantly greater injury from those reductions. Twenty-five percent of the total revenue loss of $16,000,000 will be absorbed by seven major teaching hospitals. Nearly nine percent of the total reductions will fall on one of these teaching hospitals-Cleveland Metropolitan General Hospital. Twelve percent of the total amount of the reductions will be absorbed by four children's hospitals.

41. Under the reimbursement payment imposed by Ohio Adm. Code 5101:3-2-20, hospitals are unable to eliminate or reduce their losses on Medicaid outpatient services by reducing outpatient costs because any reduction in costs results in a further reduction in Medicaid reimbursement.

42. To reduce or eliminate the revenue losses incurred under current Medicaid reimbursement reductions for hospital outpatient services, Ohio hospitals have done, and, if the reductions continue, are considering doing, some or all of the following:

a. eliminating existing outpatient services and abandoning the expansion of outpatient services;

[16] b. eliminating financial incentives to physicians to participate in outpatient programs;

c. laying off outpatient services personnel or allowing unfilled outpatient staff vacancies to remain unfilled;

d. raising charges for outpatient services in an attempt to recover the unreimbursed Medicaid costs from non-Medicaid patients;

e. performing certain procedures on an inpatient basis rather than on an outpatient basis.

43. The above measures resulting from the Medicaid reductions in outpatient reimbursement pursuant to Ohio Adm. Code 5101:3-2-20 are not consistent with quality of patient care.

4. The percentage reductions in cost reimbursement imposed by Ohio Adm. Code 5101:3-2-20, by design, require that the unreimbursed costs of Medicaid patients be shifted to non-Medicaid patients.

CONCLUSIONS OF LAW

1. The court has jurisdiction of this action, pursuant to R.C. 2743.03, to determine whether or not defendant DHS's promulgation and implementation of Ohio Adm. Code 5101:3-2-20 is arbitrary, unreasonable, in violation of relevant federal and state law, and in breach of contracts between the parties.

2. The imposition of 12 percent and 8 percent across-the-board reductions in Medicaid cost reimbursement for hospital outpatient services is not a highly discretionary decision immune from judicial review. *Children's Hospital v. Ohio Dep't of Public Welfare*, Franklin App. No. 83AP-274 [17] (November 22, 1983), unreported; *Ethicare, Inc. v. Creasy*, Franklin App. No. 84AP-285 (November 14, 1985), unreported; *Clifton Care Center, Inc. v. McKenna*, Franklin App. No. 76AP-402 (March 3, 1977), unreported; *East Haven Nursing Home, Inc. v. McKenna*, Franklin App. No. 76AP-403 (March 3, 1977), unreported.

3. If a state elects to participate in the Medicaid program, it must comply with all requirements of the Social Security Act and regulations promulgated thereunder. *Harris v. McRae*, 448 U.S. 297 (1980). The plaintiffs, as Medicaid providers and as associations representing Medicaid providers, are within the zone of interests protected under the Social Security Act and regulations promulgated thereunder, including 42 C.F.R. §447.204, and have standing to assert claims arising under those laws. *Minnesota Association of Health Care Facilities v. Minnesota Dep't of Public Welfare*, 602 F. 2d 150, 152 n. 6 (8th Cir. 1979); *National Union of Hospital & Health Care Employees v. Carey*, 557 F. 2d 278, 280 (2d Cir. 1977); *California Association of*

Bioanalysis v. Rank, 557 F. Supp. 1342, 1347 n. 6 (C.D. Calif. 1983); *Massachusetts General Hospital v. Sargeant*, 397 F. Supp. 1056, 1059 ("No significant distinction can be drawn between welfare recipients and welfare providers.")

4. Plaintiffs may assert their federal law claims in Counts I, II, III and IV of the second amended complaint before this court directly under Title XIX of the Social Security Act [18] (Medicaid), *Shady Acres Nursing Homes, Inc. v. Canary*, 39 Ohio App. 2d 47 (Franklin Co. 1973); *Washington State Health Facilities Association v. State of Washington Dep't of Social and Health Services*, 698 F. 2d 964 (9th Cir. 1982); *Edgewater Nursing Center v. Jeffrey C. Miller*, 678 F 2d 716 (7th Cir. 1982); *Wilmac Corporation v. Heckler*, 633, F. Supp. 1000, 1005 (E.D. Pa. 1986); *Troutman v. Cohen*, 588 F. Supp. 590 (E.D. Pa. 1984); and under the Supremacy Clause of Article VI of the United States Constitution. *Hillhaven Corporation v. Wisconsin Dep't of Health and Social Services*, 634 F. Supp. 1313 (E.D. Wisc. 1986). Plaintiffs' may assert their Federal constitutional claims in counts VII and VIII directly under the Fourteenth Amendment to the United States Constitution and the Supremacy Clause. *Hillhaven Corporation, supra.*

5. 42 U.S.C. §1396a(a)(13)(A) requires that a state Medicaid plan provide:

> for payment . . . of the *hospital*, skilled nursing facility, and intermediate care facility *services* provided under the plan through the use of rates . . . which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety

> standards [19] and to assure that individuals eligible for medical assistance have reasonable access . . . *to inpatient hospital services* . . . (Emphasis added.)

The plain language of Section 1396a(a)(13)(A) requires payment for all hospital services at rates reasonable and adequate to meet the costs of efficiently and economically operated facilities. This language which resulted from the "Boren Amendment," Section 2173(a)(1) of the Medicare and Medicaid Amendments of 1981, represents a change from the prior version of the statute which applied only to "inpatient hospital services." The current language of Section 1396a(a)(13)(A) clearly distinguishes between "hospital services" and "inpatient hospital services." The reasonable and adequate payment provision applies to all institutional services whether those services be of a hospital, skilled nursing facility or intermediate care facility, and whether those services be inpatient or outpatient. The assurance to reasonable access provision, on the other hand, applies only to "inpatient hospital services."

The following language of the House Energy and Commerce Committee Report on the Boren Amendment reflects the Committee's concern that state Medicaid reimbursement payments be adequate to attract a "broad scope of services" to the Medicaid program:

> The Committee is concerned that the reimbursement methods established by the [20] states recognize the need to provide *a full range of both primary care and tertiary care services* to Medicaid beneficiaries and to take into account the difference in operating costs of the *various types of facilities* needed to provide this *broad scope of services* . . . House Report No. 97-158, p. 293 (Emphasis added).

Given the above legislative history and given the greater emphasis that has been placed on outpatient services by the federal government as a costs containment alternative to costly inpatient services, it is clear that 42 U.S.C. §1396a(a)(13)(A) applies to all hospital services including outpatient services. *Wisconsin Hospital Ass'n v. Reivitz* (E.D. Wis. 1983), Medicare & Medicaid Guide (CCH 32,380).

6. The federal statutory standard Section 1396a(a)(13)(A) and its attendant legislative history clearly require that the conclusive factor in Medicaid rate determination must not be the amount of money budgeted by a given state's welfare agency or appropriated by a given state's legislature; "rather the state Medicaid agency must make an objective principled decision with regard to what rates are reasonable and adequate." *Thomas v. Johnson*, 557 F. Supp. 879, 914 (W.D. Tex. 1983). "Medicaid payment rates may not be based solely on budgetary needs." *Illinois Hospital Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 368 (N.D. Ill. 1983); see also, *Washington State Hospital Ass'n v. State of Washington* (W.D. Wash. 1987), Medicare & Medicaid Guide (CCH 36,352); *California Hospital Ass'n v. Schweiker*, 559 F. Supp. 110 (C.D. Cal. 1982), aff'd mem. 705 F. [21] 2d 466 (9th Cir. 1983); *Wisconsin Hospital Ass'n v. Reivitz* (7th Cir. 1987), Medicare & Medicaid Guide (CCH 36,329). A "state pro rate reduction plan", such as the percentage cuts here, has been found "on its face suspect." *Washington State Hospital Ass'n v. State of Washington*, supra, at p. 14,348.

The evidence establishes, and defendant's representatives admit, that in implementing the across-the-board reductions in Medicaid reimbursement rates

for outpatient services they did not consider whether the rates were reasonable and adequate to reimburse efficiently and economically operated hospitals for outpatient services provided to Medicaid recipients. Defendant's representatives also admit that the across-the-board reductions were not imposed because they found Ohio hospitals to be inefficiently or uneconomically operated. The percentage of cost reductions of Ohio Adm. Code 5101:3-2-20 were implemented only as an unpreferred and unrecommended alternative to achieve the 10 percent budgetary savings that was anticipated under a fee-for-service system which had been withdrawn by defendant as a proposed permanent rule. Furthermore, although the percentage of cost reductions were budget-driven, the reductions were not mandated by a budget deficit. The Ohio legislature actually appropriated to the DHS budget $112,000,000 more than the amount projected by DHS. Moreover, the State finished the 1988 fiscal year with a $209,000,000 surplus in the General Revenue Fund.

Ohio Adm. Code 5101:3-2-20 is a permanent rule without a stated expiration date. Even if the rule were assumed to be [22] temporary, its temporary nature would not cure its statutory infirmities. Reimbursement reduction imposed without consideration of reasonableness and adequacy, whether they be for 18 months or longer, "result in reasonable and adequate reimbursement rates only by chance and not by design." *Hillhaven Corp. v. Wisconsin Dep't of Health*, 634 F. Supp. 1313, 1320 (E.D. Wis. 1986).

Plaintiffs have demonstrated that the percentage of cost reimbursement rates implemented by Ohio Adm. Code 5101:3-2-20 do not meet the requirement of Section 1396a(a)(13)(A) that payment for hospital services be

reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Accordingly, defendant's implementation of 5101:3-2-20 violates that federal statute. Of equal importance, apart from the violation of this specific federal statute, defendant's admitted failure to reasonably and adequately reimburse efficiently an economically operated hospitals for the necessary costs incurred in treating Medicaid patients violates the basic principle that a state agency act reasonably, as well as the basic principle that the Medicaid program pay its own way for the valuable health care resources it consumes.

7. Federal Medicaid standards equivalent to those of 42 U.S.C. §1396a(a)(13) are found at 42 U.S.C. §1396a(a)(30), which requires state Medicaid programs to provide:

> such methods and procedures relating to the ... payment for, care and services available under the plan ... assure that payments [23] are consistent with efficiency, economy and quality of care.

Defendant DHS admits that Section 1396a(a)(30) applies to the reimbursement of hospital outpatient services. Defendant's representatives, however, did not consider the standards of this federal law when implementing the across-the-board reimbursement reductions of Ohio Adm. Code 5101:3-2-20.

Under defendant's current cost reimbursement principles a hospital can recover from the Medicaid program only those costs determined by Medicare and Medicaid auditors, pursuant to Medicare cost finding principles, to be both reasonable and necessary in rendering outpatient services. Ohio Adm. Code 5101:3-2-

22. The percentage of cost reductions imposed by defendant pursuant to Ohio Adm. Code 5101:3-2-20 denies payment of 12 percent (8 percent after July 1, 1988) of the costs already determined by defendant to be reasonable and necessary to the delivery of services to Medicaid patients.

The testimony presented by representatives of the hospitals establishes that if efficiently and economically operated hospitals are not permitted to recover the costs necessarily incurred in providing outpatient services to Medicaid patients, the quality of the care provided will decline. Defendant does not claim that the hospitals are operated inefficiently or uneconomically. To the contrary, defendant admits that the percent of cost reimbursement system implemented by Section 5101:3-2-20 was not intended to create incentives to deliver [24] hospital outpatient services in an efficient or economical manner.

Defendant did not implement Ohio Adm. Code 5101:3-2-20 because it found the reduced percentage of cost reimbursement payment to be consistent with efficiency, economy and quality of care. Rather, Ohio Adm. Code 5101:3-2-20 was implemented because defendant found the reduced payment to be consistent with the assumed budgetary savings anticipated under the fee-for-service method of reimbursement that was proposed as an administrative rule but was withdrawn by defendant at JCARR's insistence. Efficiency, economy and quality of care in rendering outpatient services to Medicaid recipients cannot be assured unless efficient hospitals are permitted to recover the costs of rendering those services. *Illinois Hospital Ass'n v. Illinois Department of Public Aid*, 576 F. Supp. 360 (N.D. Ill. 1983). Cost recovery for even the most efficient hospital is impossible under defendant's present payment

rate for outpatient hospital services. Plaintiffs have demonstrated that the percentage of reimbursement rate implemented by Ohio Adm. Code 5101:3-2-20 does not satisfy the federal standards of 42 U.S.C. §1396a(a)(30).

8. 42. U.S.C. §1396a(a)(2) requires that the state Medicaid program provide for financial participation on a basis which will "assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, of quality of care and services available under the plan." In interpreting this provision, courts have recognized that federal law requires that the state may not set rates based solely on [25] budgetary concerns or allow the lack of funding to lower the standards and availability of services. *Colorado Health Care Ass'n v. Colorado Dep't of Soc. Serv.*, 598 F. Supp. 1400, 1407 (D. Colo. 1984); *Friedman v. Perales*, 668 F. Supp. 216, 221 (S.D. N.Y. 1987).

Similarly, 42 C.F.R. §447.204 requires that:

> The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Under the above-quoted regulation, courts have held that by tying payment rates solely to state budgetary needs, state Medicaid agencies have totally ignored the federal mandate of 42 C.F.R. §447.204 that rates must be adequate to enlist enough health care providers so that services are available to Medicaid recipients. *Illinois Hospital Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360 (N.D. Ill. 1983).

It is not disputed that Ohio Adm. Code 5101:3-2-20 denies even the most efficient hospitals the ability to break even on the necessary and reasonable costs

incurred in caring for Medicaid recipients. Plaintiffs have established that Medicaid patients use hospital outpatient clinics and emergency rooms for primary care because of the ease of access and availability, and because such patients generally are not concerned about costs. Plaintiffs, likewise, have established that the across-the-board Medicaid cuts have a disproportionately large impact on those [26] hospitals most likely to treat Medicaid patients. Hospital outpatient clinics and emergency rooms provide a comprehensive range of health care services not generally available to Medicaid recipients in physicians' offices or other settings. By requiring hospitals to treat Medicaid patients at a loss, defendant assures a decrease in access and availability of this important source of health care to Medicaid recipients. In implementing its budget-driven reductions in outpatient reimbursement, defendant DHS has ignored the federal mandate that Medicaid payments assure availability of and access to health care services, and has thereby violated 42 U.S.C. §1396a(a)(2) and 42 C.F.R. §447.204.

9. Defendant has adopted the reasonable cost principles of the Medicare program for its reimbursement of hospital outpatient services. Ohio Adm. Code 5101:3-2-22(C). One of the fundamental principles of reasonable cost reimbursement under the Medicare and Medicaid programs is that the costs of those programs will not be shifted to individuals not covered by those programs. 42 U.S.C. §1395x(v)(1)(A); *Connecticut State Dep't of Public Welfare v. Dep't of Health, Education and Welfare*, 448 F. 2d 209 (1st Cir. 1971); *National Union of Hospital and Health Care Emp. v. Carey*, 409 F. Supp. 1197 (S.D.N.Y. 1976); *Geriatrics, Inc. v. Colorado Dep't of Social Services*, 712 F. 2d 1035 (Colo. App. 1985).

A reduced percentage cost reimbursement system by definition does not pay its own way; and the percentage of costs [27] which are not reimbursed under that system must be passed on to patients who are not covered by Medicaid. Hospital testimony confirms that the plaintiff hospitals either have already increased or are anticipating increasing charges to offset unrecovered costs on Medicaid patients. Testimony further establishes that the cost shifting problem is exacerbated in hospitals with large Medicaid, Medicare and indigent patient populations, because charge increases will not be recovered from such patients. Thus, if a hospital has a payor mix which includes only 25 percent of patients who pay full charges, the hospital has to raise charges by four dollars to recover each one dollar lost on Medicaid patients. This situation is not fair to paying patients and is expressly prohibited by 42 U.S.C. §1395x(v)(1)(A). This situation, however, is unavoidable under Ohio Adm. Code 5101:3-2-20. Defendant DHS has violated Section 1395x(v)(1)(A) by implementing a reimbursement system that shifts the burden of reasonable Medicaid costs to non-Medicaid patients.

10. Federal approval of the Medicaid plan amendment does not discharge defendant's legal duty to create a state plan in compliance with federal law. *Ethicare, Inc. v. Kenneth B. Creasy, Ohio Dep't of Welfare*, Franklin App. No. 84AP-285 (November 14, 1985) unreported. Federal approval "may not supersede a finding of arbitrary or capricious rate setting." *Id.* at p. 8.

11. In setting the reimbursement rates for hospital outpatient services, DHS has the duty under Ohio law to act [28] rationally and to consider all significant factors relevant to the reasonableness of the reimbursement

rates. *Ethicare, Inc. v. Creasy, supra; Children's Hospital v. Ohio Dep't of Public Welfare, supra. See also, State, ex rel. DeBoe v. Indus. Comm.*, 161 Ohio St. 67 (1954); *Carroll v. Dept. of Administration Savings*, 10 Ohio App. 3d 108, 110 (Franklin Co. 1983). (Administrative agencies may not issue rules which are arbitrary, unreasonable and in clear conflict with statutory enactments covering the same subject.)

The director of DHS admitted that no relevant factors were considered prior to implementing Ohio Adm. Code 5101:3-2-20. Defendant's Assistant Deputy Director of Benefits Administration admitted that the persons participating in the implementation of the percentage of cost reductions did not consider whether or not the rates would be reasonable and adequate to meet the costs which must be incurred in delivering outpatient hospital services to Medicaid recipients. The only factor considered in implementing the percentage of cost reductions was the comparison of the amount to the reductions to the hospital's overall operating budget. The comparison of the total amount of revenue reduction to total operating costs is not relevant to the reasonableness and adequacy of Medicaid rates. Likewise, the comparison is not relevant to the issues of quality of care, efficiency of operations, or availability or access to care. Accordingly, defendant's arbitrary and unreasoned implementation of Ohio Adm. Code 5101:3-2-20 to achieve a desired budgetary goal [29] violated its duty as an administrative agency to act rationally in establishing reimbursement rates.

12. DHS adopted Ohio Adm. Code 5101:3-2-20 as an emergency rule to temporarily reduce reimbursement of hospital outpatient services under the cost-based method of reimbursement while JCARR reviewed a

proposed permanent fee-for-service rule. When DHS withdrew the proposed permanent fee-for-service rule it readopted Ohio Adm. Code 5101:3-2-20 as an emergency rule.

The adoption and validity of emergency rules are governed by R.C. 119.03(F), which provides, in pertinent part:

> The emergency rule . . . shall become invalid at the end of the ninetieth day it is in effect. *Prior to that date the agency may adopt the emergency rule . . . as a nonemergency rule* . . . by complying with the procedure prescribed by this section for adoption . . . of nonemergency rules. The agency may not use the procedure of this division to readopt the emergency rule . . . becoming invalid under this division, the emergency rule . . . will continue in effect without interruption for another ninety-day period. (Emphasis added.)

R.C. 119.03(F) grants administrative agencies, such as DHS, the power to adopt emergency rules for a limited period of 90 days. At the end of the 90-day period, the emergency rule becomes invalid. During that 90-day period, the agency may adopt the emergency rule as a nonemergency rule by complying with the rulemaking procedures of R.C. 119.03 Section 119.03(F) does not permit the readoption of emergency rules as emergency rules. If the Ohio General Assembly had intended to allow the readoption of [30] an emergency rule for a second period of up to 89 days, it would have expressed that intent. *Cincinnati v. Roettinger*, 105 Ohio St. 145, 152 (1922); *Heath v. Licking County Regional Airport Authority*, 16 Ohio Misc. 69 (1967). The readoption of the emergency rule version of Ohio Adm. Code 5101:3-2-20 clearly violates R.C. 119.03(F), and the readopted emergency rule was void *ab initio*.

13. A majority of the member hospitals and plaintiff hospitals are required by the community service assurances obligations of the Public Health Service Act (Hill-Burton Act) to participate perpetually in the Medicaid program. 42 C.F.R. §124.603(c); *American Hospital Ass'n v. Schweiker*, 721 F. 2d 170 (7th Cir. 1983). Thus, the hospitals may not choose to withdraw from the Medicaid program as a result of defendant's refusal to provide adequate and reasonable rates of compensation. Additionally Section 9121 of the Consolidated Omnibus Budget Reconciliation Act of 1985 imposes upon all hospitals participating in the Medicare and Medicaid programs the absolute responsibility to examine medically any individual who comes to the hospital's emergency department and requests examination or treatment. 42 U.S.C. §1395dd. The hospitals may not refuse to examine any patient who comes to the emergency room even if examination in a physician's office or other setting may be less costly. Pursuant to these federal laws, hospitals are required, by law, to devote valuable resources to Ohio's Medicaid program. Ohio Adm. Code 5101:3-2-20 precludes even the most efficient [31] hospital from recovering the reasonable costs necessarily incurred in providing such resources to recipients of the Medicaid program. Ohio Adm. Code 5101:3-2-20 is clearly unjust, unreasonable and confiscatory, and its application deprives member hospitals and plaintiff hospitals of property in violation of the Fourteenth Amendment of the United States Constitution and Article I, Section 2 of the Ohio Constitution. *Bluefield Water Works & Improvement Co. v. Public Service Comm'n*, 262 U.S. 679, 690 (1923).

14. Ohio Adm. Code 5101:3-2-20 singles out hospitals from other providers of outpatient services for a reduction in the payment of costs already determined by defendant to be reasonable and necessary to the provision of services to Medicaid recipients. The budget-driven reimbursement reductions further discriminate among hospitals by impacting more heavily on teaching hospitals, children's hospitals and hospitals with high Medicaid populations. The Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution and of Article 1, Section 2 of the Ohio Constitution prohibit discriminatory classifications that lack a rational relationship to a legitimate state interest. *State ex rel. Dayton Fraternal Order of Police Lodge No. 44 v. State Corp. Relations Bd.*, 22 Ohio St. 3d 1 (1986). The arbitrary, across-the-board reductions in Medicaid payments for hospital outpatient services violate that prohibition.

Defendant's motivation in imposing the reductions in [32] outpatient Medicaid payment was not based upon a determination that all hospitals or certain hospitals were less cost efficient in delivering outpatient services to Medicaid recipients than other providers or other hospitals. Defendant made no such determination. Defendant's motivation for imposing the reductions rather was purely budgetary. No reasoned study supported the across-the-board reductions. Both federal and Ohio courts have found such budget-driven, across-the-board reductions in Medicaid payments arbitrary and in violation of the Social Security Act. Such reductions imposed by Ohio Adm. Code 5101:3-2-20 ignore defendant's duty to comply with federal Medicaid reimbursement standards, and, therefore, cannot be rationally related to a legitimate state interest. The

Franklin County Court of Appeals has held expressly that Defendant DHS does not have authority to discriminatorily impose reductions in Medicaid payments in response to insufficient appropriations. *Clifton Care Center, Inc. v. McKenna* and *East Haven Nursing Home, Inc. v. McKenna*, Franklin App. Nos. 76AP-402, 76AP-403 (March 3, 1977), unreported. The arbitrary and discriminatory reductions of Ohio Adm. Code 5101:3-2-20 violate the Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution and Article I, Section 2 of the Ohio Constitution.

15. Defendant DHS does not contend that plaintiff hospitals and member hospitals have failed to perform their obligations [33] under their respective Medicaid provider agreements. Defendant's obligation under those provider agreements, in turn, "is to make payment at the proper rate to plaintiff for care rendered to individuals who are eligible for welfare assistance under the program involved." *Crestwood Nursing Home v. White*, Franklin App. No. 76AP-839, p. 7 (June 7, 1977), unreported. Defendant has breached that obligation by the arbitrary, budget-driven reductions of Ohio Adm. Code 5101:3-2-20.

16. For all of the foregoing reasons, this court concludes that plaintiffs are entitled to the declaratory, monetary and injunctive relief sought in the Second Amended Complaint against defendant DHS.

17. The evidence has established the following:

1. Spiraling Medicaid costs are out of control.

2. DHS in conjunction with the Ohio General Assembly has the power to adopt a state plan to improve this situation by:

a. Promptly adopting a prospective fee for service system, and

b. Requiring the Medicaid recipient to seek the most cost efficient means of treatment. Why should poor and needy patients be treated better than the average paying citizen who would ordinarily go to a doctor's office for normal medical care-rather than to a hospital where the fee is two or three times as much? Obviously there are times when medical treatment in a [34] hospital facility is required but convenience is a very poor excuse for extravagance at public expense.

/s/ FRED J. SHOEMAKER
Judge

JUDGMENT ENTRY OF THE COURT OF CLAIMS

(Filed November 2, 1988)

Case No. 88-04961

IN THE COURT OF CLAIMS OF OHIO

OHIO HOSPITAL ASSOCIATION, *et al.*,
Plaintiffs,

v.

THE DEPARTMENT OF HUMAN SERVICES,
Defendant.

JUDGMENT ENTRY

FRED J. SHOEMAKER, *Judge*

Upon consideration of all the evidence and for the reasons set forth in the decision rendered concurrently herewith,

IT IS THEREFORE ORDERED, DECREED AND ADJUDGED THAT:

I. All emergency and non-emergency rule versions of Ohio Adm. Code 5101:3-2-20 are void *ab initio* as a violation of the Social Security Act, 42 U.S.C. §1395x(v)(1)(A), 1396a(a)(13)(A), 1396a(30)(A), and 1396a(a)(2), and the regulations promulgated thereunder, 42 C.F.R. §447.204, the Supremacy Clause of Article VI of the United States Constitution, the Due Process Clause of the Fourteenth Amendment of the United States Constitution, and of Article I, Section 2 of the

Ohio Constitution, as an arbitrary and unreasonable administrative rule promulgated outside of the authority delegated to defendant DHS.

II. The second emergency rule version of Ohio Adm. Code 5101:3-2-20 was void *ab initio* on the additional ground that it constituted the readoption and continuation of an existing emergency rule in violation of R.C. 119.03(F).

[2] III. Defendant DHS, its officers, agents, servants, employees and attorneys and persons acting in active concert or participation with them, are permanently enjoined from applying Ohio Adm. Code 5101:3-2-20 to reduce Medicaid reimbursement of Ohio hospitals.

IV. Defendant DHS shall pay the costs of this action.

/s/ FRED J. SHOEMAKER
Judge

Entry cc:

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OHIO ADMINISTRATIVE CODE

5101:3
Division of Medical Assistance

5101:3-2-20 Limits on reimbursement for outpatient hospital services

Effective with the date of this rule, payments for outpatient hospital services reimbursed on a cost-related basis will be limited to the lesser of eighty-eight per cent of reasonable costs as such costs are described in paragraphs (B) and (C) to (C)(1)(f) of rule 5101:3-2-22 of the Administrative Code or eighty-eight per cent of billed charges for services furnished to eligible recipients.

(A) Interim payments

Interim payments will be made on a percentage of billed charges basis. The interim payment percentage will be calculated by multiplying the hospital's cost-to-charge per cent described in paragraph (B)(3) of rule 5101:3-2-22 of the Administrative Code by .88. For purposes of establishing upper limits for general relief, the percentage described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code will be recalculated to determine a percentage specific to inpatient services and one specific to outpatient services. The general relief percentage for outpatient will be multiplied by .88 to establish the upper limit for general relief outpatient interim payments. The interim payment percentages described in this paragraph will be calculated and applied to billed charges as shown in the following example:

90%	hospital's cost-to-charge per cent
x.88	limitation factor
= 79.2%	interim payment per cent

$100	hospital's billed charges
x.792	payment per cent
=$79.20	interim payment

(B) Audits

Effective with the date of this rule, the scope of audits described in rule 5101:3-2-24 of the Administrative Code is expanded to include the provisions of this rule. That is, in determining through audit whether costs are reasonable and allowable as described in paragraph (B)(1)(d) of rule 5101:3-2-24 of the Administrative Code, otherwise reasonable and allowable costs will be multiplied by .88 to determine audited allowable costs. Similarly, in determining whether payments exceed charges, as provided in paragraph (B)(1)(f) of rule 5101:3-2-24 of the Administrative Code, otherwise allowable charges will be multiplied by .88 to determine audited allowable charges.

(C) Method of implementation

(1) Interim payments

For the purposes of paragraph (A) of this rule, revised interim payment per cents shall apply to outpatient services provided on after [sic] the effective date of this rule. In instances when a recipient receives services over a period of time beginning prior to the effective date of this rule and ending on or after the effective date of this rule and when such services are billed on one UB-82 invoice form, the end date of service will be referenced in determining the amount of payment.

If, for example, a UB-82 invoice is submitted carrying charges associated with multiple service dates and showing an end date of service prior to the effective date of this rule the provisions of paragraph (A) of this rule will not apply in calculating interim payment amount. If an invoice is submitted carrying charges associated with multiple service dates and showing an end service date on or after the effective date of this rule, the interim payment per cent described in paragraph (A) of this rule will be applied to total allowable invoice charges in calculating interim payment amount.

(2) Audit settlements

For the purpose of interm and final settlements the provisions of paragraph (B) of this rule shall apply to costs and charges for that portion of the cost reporting period associated with service dates beginning on and after the effective date of this rule.

HISTORY: Eff. 1-4-88

5101:3-2-20

LIMITS ON REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

Effective with the date of this rule, payments for outpatient hospital services reimbursed on a cost-related basis will be limited to the lesser of eighty-eight per cent of reasonable costs as such costs are described in paragraphs (B) and (C) to (C)(1)(F) of rule 5101:3-2-22 of the Administrative Code or eighty-eight per cent of billed charges for services furnished to eligible recipients. Effective July 1, 1988, the per cent described in this paragraph is revised from eighty-eight to ninety-two. Services reimbursed on a cost-related basis which are subject to the provisions of this rule include all covered outpatient hospital services except laboratory services which are reimbursed in accordance with rule 5101:3-1-60 of the Administrative Code and, effective July 1, 1988, radiology services which are subject to the provisions of rule 5101:3-2-21 of the Administrative Code.

(A) INTERIM PAYMENTS

Interim payments will be made on a percentage of billed charges basis. The interim payment percentage will be calculated by multiplying the hospital's cost-to-charge per cent described in paragraph (B)(3) of rule 5101:3-2-22 of the Administrative Code by .88 effective with the date of this rule and by .92 effective July 1, 1988. For purposes of establishing upper limits for general assistance, the percentage described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code will be recalculated to determine a percentage specific to inpatient services and one specific to outpatient services. The general assistance percentage for outpatient will be multiplied by .88

effective with the date of this rule and by .92 effective July 1, 1988 to establish the upper limit for general assistance outpatient interim payments. The interim payment percentages described in this paragraph will be calculated and applied to billed charges as shown in the following example:

Effective Date of This Rule		Effective July 1, 1988
90%	Hospital's cost-to-charge per cent	90%
X.88	Limitation Factor	X.92
= 80%	Interim payment per cent	= 83%
$ 100	Hospital's billed charges	$ 100
X 792	Payment per cent	X.828
=$80.00	Interim payment	=$ 83.00

(B) AUDITS

Effective with the date of this rule, the scope of audits described in rule 5101:3-2-24 of the Administrative Code is expanded to include the provisions of this rule. That is, in determining through audit whether costs are reasonable and allowable as described in paragraph (B)(1)(D) of rule 5101:3-2-24 of the Administrative Code. Otherwise reasonable and allowable costs will be multiplied by .88 to determine audited allowable costs. Similarly, in determining whether payments exceed charges, as provided in paragraph (B)(1)(F) of rule 5101:3-2-24 of the Administrative Code. Otherwise allowable charges will be multiplied by .88 to determine audited allowable charges. Effective July 1, 1988, the per cent described in this paragraph is revised from eighty-eight to ninety-two.

(C) METHOD OF IMPLEMENTATION

(1) INTERIM PAYMENTS

For the purposes of paragraph (A) of this rule, revised interim payment per cents shall apply to outpatient services provided on after the effective date of this rule for the eighty-eight per cent limitation or on or after July 1, 1988 for the ninety-two per cent limitation. In instances when a recipient receives services over a period of time that spans the effective date of this rule and when such services are billed on one UB-82 invoice, the end date of service will be referenced in determining the amount of payment.

If, for example, a UB-82 invoice is submitted carrying charges associated with multiple service dates and showing an end date of service prior to the effective date of this rule, the provisions of paragraph (A) of this rule will not apply in calculating interim payment amount. If an invoice is submitted carrying charges associated with multiple service dates and showing an end service date on or after the effective date of this rule. The eighty-eight per cent limitation described in paragraph (A) of this rule will be applied to total allowable invoice charges in calculating interim payment amount. As described in paragraph (C) of rule 5101:3-2-21 of the Administrative Code. Providers may not submit invoices with multiple service dates that span July 1, 1988. If an invoice is submitted carrying charges associated with multiple service dates and showing both a beginning service date and an end service date on or after July 1, 1988. The ninety-two per cent limitation described in paragraph (A) of this rule will be applied to total allowable invoice charges in calculating interim payment amounts.

(2) AUDIT SETTLEMENTS

For the purpose of interim and final settlements, the provisions of paragraph (B) of this rule reflecting an eighty-eight per cent limitation shall apply to costs and charges for that portion of the cost-reporting period associated with service dates beginning on and after the effective date of this rule, and ending prior to July 1, 1988. For that portion of the cost-reporting period associated with service dates beginning on and after July 1, 1988. The provisions of paragraph (B) of this rule reflecting a ninety-two per cent limitation shall apply.

Effective Date: APR 23 1988

Certification: PATRICIA BARRY
APR 13 1988
Date

Promulgated Under Revised Code Chapter 119.

Statutory Authority Revised Code Section 5111.02

Prior Effective Date: 1/4/88 (Emer.)

Supreme Court, U.S.
FILED
FEB 26 1992
OFFICE OF THE CLERK

No. 91-1297

In the Supreme Court of the United States

OCTOBER TERM, 1991

OHIO DEPARTMENT OF HUMAN SERVICES
Petitioner,

VS.

OHIO HOSPITAL ASSOCIATION, et al.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF OHIO

BRIEF FOR THE RESPONDENTS IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a reduction by a State in existing Medicaid reimbursement rates for outpatient hospital services that was imposed solely to meet budgetary constraints without regard to whether the payments pursuant to the reduction were consistent with efficiency, economy, and quality of care violates 42 U.S.C. Sec. 1396a (a) (30) (A).

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OCTOBER TERM, 1991

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ON PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF OHIO

BRIEF FOR THE RESPONDENTS IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

OPINIONS BELOW

The opinion of the Ohio Supreme Court, Pet. App. A1-A15, is reported at 62 Ohio St. 3d 97. The opinions of the Court of Appeals of Franklin County, Ohio, Tenth Appellate Disctrict, Pet. App. A.16-A39, and the Court of Claims, State of Ohio, Pet. App. A40-A69, are not reported.

JURISDICTION

Respondents do not take issue with Petitioner's statement respecting jurisdiction.

STATUTORY PROVISION INVOLVED

Respondents do not take issue with Petitioner's statement respecting the statutory provision involved.

STATEMENT OF THE CASE

In its Statement of the Case, Petitioner has selectively chosen certain findings of the Court of Claims a substantial number of which are irrelevant to the issue being presented to this Court.[1] The following additional facts of that Court are necessary for a proper understanding of this case.

Respondents brought suit in the Court of Claims, State of Ohio, alleging that Petitioner's implementation of Ohio Adm. Code 5101:3-2-20 was arbitrary, unreasonable, in violation of federal and state law, and in breach of contract. In finding in favor of the Respondents, the Court of Claims made the following factual determinations:

1. Petitioner was not contending that the Medicaid cuts in reimbursement for hospital outpatient services were made in response to a determination that Ohio hospitals were operating inefficiently. Finding of Fact ("FF") #29 (Pet. App. A49).

2. Petitioner did not conduct any study or analysis prior to implementing either the emergency or permanent rule versions of Ohio Adm. Code 5101:3-2-20 to

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[1]For example, the State's intention to adopt a prospective payment system for outpatient services has no bearing on the issue before this Court in that the prospective payment system was not adopted during the time period at issue and did not form the basis for the challenged reimbursement method.

determine that the reduction in cost-based reimbursement was:

a. reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities;

b. consistent with efficiency, economy, and quality of care;

c. adequate to assure availability of and access to Medicaid services;

d. adequate to assure that costs of Medicaid patients will not be borne by non-Medicaid patients.

FF #33 (Pet. App. A50-A51).

3. The adoption of Ohio Adm. Code 5101:3-2-20 was based solely on Petitioner's budgetary needs. FF #35 (Pet. App. A51).

4. Hospitals with high Medicaid outpatient utilizations, such as teaching hospitals, children's hospitals, and hospitals located in poverty areas absorb the majority of the Medicaid reductions and would suffer significantly greater injury from those reductions. Twenty-five percent (25%) of the total revenue loss of $16,000,000 would be absorbed by seven major teaching hospitals. Nearly nine percent (9%) of the total

Twelve percent (12%) of the total amount of the reductions would fall on one of these teaching hospitals — Cleveland Metropolitan General Hospital. Twelve percent (12%) of the total amount of the reductions would be absorbed by four children's hospitals. FF #40 (Pet. App. A52).

5. Under the reimbursement plan imposed by Ohio Adm. Code 5101:3-2-20, hospitals were unable to eliminate or reduce their losses on Medicaid outpatient services by reducing outpatient costs because any reduction in costs resulted in a further reduction in Medicaid reimbursement. FF #41 (Pet. App. A53).

6. To reduce or eliminate the revenue losses incurred pursuant to Ohio Adm. Code 5101:3-2-20 for hospital outpatient services, Ohio hospitals had done and, if the reductions continued, were considering doing, some or all of the following, none of which were consistent with quality of patient care:

   a. eliminating existing outpatient services and abandoning the expansion of outpatient services;

   b. eliminating financial incentives to physicians to participate in outpatient programs;

   c. laying off outpatient services personnel or allowing unfilled outpatient staff vacancies to remain unfilled;

   d. raising charges for outpatient services in an attempt to recover the unreimbursed Medicaid costs from non-Medicaid patients;

e. performing certain procedures on an inpatient basis rather than on an outpatient basis.

FF #42, 43 (Pet. App. A53).

7. The percentage reductions in cost reimbursement imposed by Ohio Adm. Code 5101:3-2-20, by design, required that the unreimbursed costs of Medicaid patients be shifted to non-Medicaid patients. FF #44 (Pet. App. A53).

The Franklin County Court of Appeals concurred in the Findings of Fact of the Court of Claims based not only upon the standard of review which requires deference to the trial court's evidentiary findings but, also, based upon the Court of Appeals' own review of the record in this case. See, Court of Appeals Decision at Pet. App. A30 ("[A] review of the voluminous record and transcript supports the trial court's conclusions.")[2]

With respect to Petitioner's assignments of errors related to federal law, the Court of Appeals stated:

> In sum, there is a dearth of evidence to suggest that ODHS applied the standard of Section 1396(a) (30) (A), Title 42, U.S. Code, prior to implementing Ohio Adm. Code 5101:3-2-20.
>
> ***

[2]The Court of Claims and the Court of Appeals also both found that Ohio Adm. Code 5101:3-2-20 had been readopted as an emergency rule in violation of Ohio Revised Code Sec. 119.03 (F) and became void ab initio as of its readoption on March 31, 1988. Court of Claims Decision at Pet. App. A65;Court of Appeals Decision at Pet. App. A35-A36. The permanent version of the rule was effective April 23, 1988. Pet. App. A47.

> The other provisions of federal law disputed by ODHS as being applicable and/or violated include Section 1396 (a) (13) (A), Title 42, U.S. Code (the Boren Amendment), Sections 1396 (a) (2) and 1395x(v) (1) (A), Title 42, C.F.R. Given our discussion above of Section 1396 (a) (30) (A), it is clear that, in enacting Ohio Adm. Code 5111:3-2-20 [sic], ODHS also failed to comply with any of the standards enunciated by those provisions. Even assuming, nonetheless, that the trial court erred in determining that one or all of the provisions applies under these facts, any error is non-prejudicial in light of our holding as to Section 1396 (a) (30) (A). Accordingly, assignments of error numbers two, five, six, seven, eight, nine, ten, and eleven...are not well-taken.

Court of Appeals Decision at Pet. App. A31-A32.

Petitioner then filed a Memorandum in Support of Jurisdiction with the Ohio Supreme Court raising two propositions of law — one based upon the Fourteenth Amendment to the United States Constitution (which the Ohio Supreme Court subsequently declined to consider), and one based upon 42 U.S.C. Sec. 1396a(a) (30) (A). Petitioner did not raise any issue with respect to the Court of Appeals' rejection of Petitioner's other assignments of error based upon federal law nor did the Ohio Supreme Court consider any such federal issues.

The Ohio Supreme Court affirmed the decision of the Court of Appeals mooting only that portion of the lower court's decision relating to the Fourteenth Amendment. See, Ohio Supreme Court Decision at Pet. App. A-9.

ARGUMENT IN OPPOSITION

Rule 10 of the Rules of the Supreme Court of the United States provides the character of reasons that will be considered by this Court in determining whether to exercise its jurisdiction. With respect to decisions by a state court of last resort, Rule 10 provides that consideration may be given:

(b) When a state court of last resort has decided a federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals.

(c) When a state court...has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.

The decision of the Ohio Supreme Court in this case fails to meet any of these criteria. Rather, the decision is consistent with the plain language of the statute at issue and the decisions of federal courts. Accordingly, no special or important reasons exist which warrant this Court to exercise its jurisdiction.

In Wilder v. Virginia Hospital Association, 496 U.S. ___, 110. S. Ct. 2510, 110 L. Ed. 2d 455 (1990), this Court made clear that a State may not act arbitrarily and unreasonably in setting rates under the Medicaid program. Rather, the reasonableness of the rates set by the State must be judged "against the objective benchmark of an 'efficiently and economically operated facility' providing care in compliance

with federal and state standards while at the same time ensuring 'reasonable access' to eligible participants." Id., 496 U.S. at ___; 110 L. Ed. 2d at 473. Accord, AMISUB (PSL), Inc. v. State of Colorado Department of Social Services, 879 F.2d 789, 800 (10th Cir. 1989), cert. denied, ___ U.S. ___, 110 S. Ct. 3212, 110 L. Ed. 2d 660 (1990) (while a State may consider budgetary constraints, budgetary constraints cannot excuse noncompliance with federal Medicaid law).

Petitioner has come before this Court asking that it ignore Supreme Court precedent and the factual findings of the courts below in order that Petitioner may avoid its legally mandated duty. Petitioner's arguments are not supported by the law or the facts of this case and, therefore, do not justify this Court exercising its jurisdiction.

A. Interpretation of 42 U.S.C. Sec. 1396a(a) (30) (A)

In an attempt to create an argument for this Court to consider, Petitioner states that the Ohio Supreme Court erroneously construed 42 U.S.C. Sec. 1396a(a) (30) (A) as establishing a minimum Medicaid rate. The concept of "minimum rate," however, was never an issue with the courts below. As was stated by the Ohio Supreme Court:

> ODHS is correct in asserting that the statute does not set a minimum rate of reimbursement in recognition of the varying and limited nature of state resources...However, the courts below did not hold that Ohio Adm. Code 5101:3-2-20 violated a set minimum rate.

Ohio Supreme Court Decision at Pet. App. A6-A7; see also, Court of Appeals Decision at Pet. App. A29-A30 ("It is clear

from the trial court's decision that the issue was not whether hospitals were reimbursed at a minimum rate but, rather, whether ODHS complied with federally mandated standards in enacting Ohio Adm. Code 5101:3-2-20.").

This lawsuit was brought on several grounds including a claim that Petitioner failed to comply with the plain language of 42 U.S.C. 1396a(a) (30) (A). That statute provides, in pertinent part, that a State plan for medical assistance must provide methods and procedures as are necessary "to assure that payments are consistent with efficiency, economy, and quality of care."

In interpreting this provision, the Ohio Supreme Court found that the State was required to make findings that its rates were reasonable and adequate prior to implementation. Such an interpretation is consistent with the decisions of other courts which have interpreted Section 1396a(a) (30) (A). Lexington Management Co., Inc. v. Missouri Department of Social Services, 656 F. Supp. 36, 45 (W.D. Mo. 1986) (Section 1396a(a) (30) requires the State to fund providers at proper levels); Illinois Hospital Association v. Illinois Department of Public Aid, 576 F. Supp. 360, 370 (N.D. Ill. 1983) (State preliminarily enjoined from deferring 23.5% of final hospital reimbursement due to budgetary crisis because plan failed to satisfy federal requirement that Medicaid reimbursement rates be sufficient to insure quality care).

In the present case, the evidence presented to the courts below established that the payments in question were not consistent with efficiency, economy, and quality of care. Under the Petitioner's then current cost reimbursement principles, a hospital could recover only those costs determined by

Medicare and Medicaid auditors, pursuant to Medicare cost finding principles, to be both reasonable and necessary in rendering outpatient services. Ohio Adm. Code 5101:3-2-22. This formula was not disputed. Ohio Adm. Code 5101:3-2-20, however, took the amount which was calculated pursuant to Section 5101:3-2-22 and reduced this amount effective January 4, 1988, by 12% (8% after July 1, 1988) solely as a means of resolving budget problems i.e., the Petitioner substantially reduced the amount which the Petitioner had already determined was reasonable and necessary to the delivery of services to Medicaid patients.

As such, the actions of Petitioner were inherently unreasonable in that the Petitioner had taken a system which it had certified to the federal government as providing payments "which are consistent with efficiency, economy, and quality of care," and then arbitrarily reduced the payments by 12% and then 8% as a way of achieving budgetary savings (even though the reductions were not mandated by a budget deficit). Court of Clams Decision at Pet. App. A58. As was stated by the Tenth Circuit in AMISUB (PSL), Inc., 879 F.2d at 801 (citing Alabama Nursing Home Assn. v. Califano, 433 F.Supp. 1325, 1330 (M.D. Ala. 1977), rev'd and vacated in part on other grounds sub nom. 617 F.2d 388 (5th Cir. 1980)), "If a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will."

Based upon the particular facts of this case, the Ohio Supreme Court held that:

> Former Ohio Adm. Code 5101:3-2-20 violates Title XIX of the Social Security Act, Section 1396a(a) (30) (A), Title 42, U.S. Code, because it was implemented solely for budgetary reasons, without consideration of its effect on the quality of care provided by the Medicaid program.

Ohio Supreme Court Decision at Pet. App. A1, para. 1 of syllabus.

Accordingly, the cases cited by Petitioner for the proposition that Section 1396a(a) (30) (A) prescribes no minimum Medicaid rates are irrelevant to this case. Furthermore, in none of these cases did the courts hold that payments pursuant to a State plan were not subject to judicial scrutiny or that a State was permitted to make payments with total disregard as to whether they served the purposes of efficiency, economy, or quality of care. See, e.g., Briarcliff Haven, Inc. v. Department of Human Services of Georgia, 403 F. Supp. 1355, 1362 (N.D. Ga. 1975) (Section 1396a(a) (30) (A) does not require a specific minimum payment so long as payment made was consistent with efficiency, economy, and quality of care). The District Court for the Southern District of Ohio, in an analogous case, has also specifically rejected Petitioner's argument:

> Whether a "minimum fee" has been established begs the question. Certainly, if a rate is so low as to be unreasonable, it is below an acceptable minimum. The real questions are

whose survey and what factors should determine the reasonableness of the fee.

Ohio State Pharmaceutical Association v. Creasy, 587 F. Supp. 698, 708 (S.D. Ohio 1984).

As is further evident from the above, the issue before the Ohio Supreme Court was not purely one of law; rather, the issue before the Court was whether the facts established that the Petitioner had determined that the rate reductions were consistent with efficiency, economy, and quality of care prior to their implementation as is required by 42 U.S.C. Section 1396a(a)(30)(A).[3] It has long been a guiding principle of this Court that it will not hear cases which involve mixed questions of law and fact or which "involve or imply conclusions or judgment by the Court upon the effect of facts adduced in the

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[3]The Court of Appeals also characterized Petitioner's argument as an evidentiary rather than legal dispute.

> ODHS does not dispute the applicability of Section 1396a(a)(30)(A) to this action. However, ODHS interprets the trial court's decision as requiring hospitals to be reimbursed one hundred percent of the costs they have incurred in providing outpatient services to Medicaid patients. Basically, ODHS challenges the manifest weight of the evidence....
>
> We cannot agree with the interpretation advanced by ODHS. It is clear from the trial court's decision that the issue was not whether hospitals were reimbursed at a minimum rate but, rather, whether ODHS complied with federally mandated standards in enacting Ohio Adm. Code 5101:3-2-20. The decision is replete with references to efficiency, economy, and quality of care, and the concomitant failure of ODHS to consider these standards....

Court of Appeals Decision at A29-A30. (Emphasis added.)

cause..." Pflueger v. Sherman, 293 U.S. 55, 58, 55 S.Ct. 10, 79 L.Ed. 193 (1934); Triplett v. Lowell, 297 U.S. 638, 648-49, 56 S.Ct. 645, 80 L.Ed. 949 (1935).

Applying the legal standard prescribed by Section 1396a(a)(30)(A) to the facts of this case, the Court of Claims held that (1) the reductions were not imposed because hospitals were inefficiently or uneconomically operated; (2) the reductions were implemented only as an unpreferred and unrecommended alternative to achieve the 10% budgetary savings that was anticipated under an alternative system which had been withdrawn by the Petitioner; and (3) the reductions were not mandated by a budget deficit. Court of Claims Decision at Pet. App. A57-A61.

Applying this legal standard to the facts of this case, the Court of Appeals held that there was "a dearth of evidence to suggest that ODHS applied the standard of Section 1396a(a)(30)(A)...." Court of Appeals Decision at Pet. App. A31.

Applying this legal standard to the facts of this case, the Ohio Supreme Court deferred to the finding of the Court of Claims that Section 5101:3-2-20 was adopted solely for budgetary reasons without consideration of its effect on the quality of care provided by the Medicaid program. The Court therefore found that Section 5101:3-2-20 was violative of 42 U.S.C. Sec. 1396a(a)(30)(A). Ohio Supreme Court Decision at Pet. App. A1 at para. 1 of syllabus, A9.

B. Applicability of 42 U.S.C. Sec. 1396a(a)(13)(A)

Petitioner further argues that the Ohio Supreme Court "erroneously engraphed [sic] the requirements of the Boren

Amendment onto 42 U.S.C. Sec. 1396a(a)(30)(A)" in reaching its decision. A plain reading of the Court's decision, however, reflects that this argument is also a misrepresentation of the Ohio Supreme Court's decision.

In analyzing this case, the Ohio Supreme Court recognized that the Medicaid statutes, in general, "impose a duty on state programs to adequately reimburse their Medicaid providers." Ohio Supreme Court Decision at Pet. App. A7. In support of this general proposition, the Court considered decisions interpreting the Boren Amendment, 42 U.S.C. Sec. 1396a(a)(13)(A), with respect to the issue of State cuts in Medicaid payments based solely upon budgetary concerns. Ohio Supreme Court Decision at Pet. App. A8-A9. At no time did the Court state that it was engrafting the requirements of the Boren Amendment onto Section 1396a(a)(30)(A) or otherwise basing its decision on any federal statute other than Section 1396a(a)(30)(A).[4] Nor did Petitioner raise any proposition of law regarding 42 U.S.C. Sec. 1396a(a)(13)(A) before the Ohio Supreme Court. The fact that Petitioner characterizes the Ohio Supreme Court's decision in such a manner does not create an issue justifying this Court exercising its jurisdiction.

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[4] Paragraph 1 of the syllabus in this case speaks solely to 42 U.S.C. Sec. 1396a(a)(30)(A) and does not mention Section 1396a(a)(13)(A). Rule 1 of the Ohio Supreme Court Rules for the Reporting of Opinions provides that with respect to Ohio Supreme Court opinions (other than those rendered per curiam), "The syllabus of a Supreme Court opinion states the controlling point or points of law decided in and necessarily arising from the facts of the specific case before the Court for adjudication." Accord, Baltimore & Ohio Railroad Co. v. Baillie, 112 Ohio St. 567, 567 para. 2 of syllabus (1925); Cassidy v. Glossip, 12 Ohio St. 2d 17, 24 (1967).

CONCLUSION

The Court of Claims of the State of Ohio, the Court of Appeals of Franklin County, Ohio, and the Ohio Supreme Court have each found that 42 U.S.C. Sec. 1396a(a) (30) (A) requires a State to consider, as part of its State plan for medical assistance, whether its rates will provide payments that are consistent with efficiency, economy, and quality of care. Based upon the evidence presented, as initially determined by the Court of Claims, and as subsequently reaffirmed by the Court of Appeals and the Ohio Supreme Court based upon an independent review of the record, these courts found that Petitioner's across-the-board cut was implemented by Petitioner solely based upon budgetary concerns and without regard to reasonableness, adequacy, or its effect on efficiency, economy, or quality of care.

As such, no legal issue has been presented in this petition which warrants consideration by this Court. The Ohio Supreme Court's decision was amply supported by both the law and the facts and is consistent with United States Supreme Court precedent.

Respondents therefore urge this Court to deny Petitioner's Petition for a Writ of Certiorari.

Respectfully submitted,

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APPENDIX

Rule 10. Considerations Governing Review on Writ of Certiorari

.1. A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered:

(a) When a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter; or has decided a federal question in a way in conflict with a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's power of supervision.

(b) When a state court of last resort has decided a federal question in a way that conflicts with the decision of another state court of last resort or of a United States court of appeals.

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.

.2. The same general considerations outlined above will control in respect to a petition for a writ of certiorari to review a judgment of the United States Court of Military Appeals.

Rule 1. Supreme Court Opinions

(A) All opinions of the Supreme Court shall be reported in the Ohio Official Reports.

(B) The syllabus of a Supreme Court opinion states the controlling point or points of law decided in and necessarily arising from the facts of the specific case before the Court for adjudication.

(C) In a *per curiam* opinion of the Supreme Court, the point or points of law decided in the case are contained within the text of each *per curiam* opinion and are those necessarily arising from the facts of the specific case before the Court for adjudication.

§ 119.03 Procedure for adoption, amendment, or rescission of rules.

In the adoption, amendment, or rescission of any rule, an agency shall comply with the following procedure:

(A) Reasonable public notice shall be given at least thirty days prior to the date set for a hearing, in the manner and form and for the length of time as the agency determines and shall include:

(1) A statement of the agency's intention to consider adopting, amending, or rescinding a rule;

(2) A synopsis of the proposed rule, amendment, or rule to be rescinded or a general statement of the subject matter to which the proposed rule, amendment, or rescission relates;

(3) A statement of the reason or purpose for adopting, amending, or rescinding the rule;

(4) The date, time, and place of a hearing on the proposed action, which shall be not earlier than thirty nor later than fifty days after the proposed rule, amendment, or rescission is filed under division (B) of this section. In addition to public notice, the agency may give whatever other notice it considers necessary. Each agency shall adopt a rule setting forth in detail the method that the agency shall follow in giving public notice as to the adoption, amendment, or rescission of rules. The rule shall require the agency to provide the public notice

required under division (A) of this section to any person who requests it and pays a reasonable fee, not to exceed the cost of copying and mailing. The methods used for notification may include, but are not limited to, mailing notices to all subscribers on a mailing list or mailing notices in addressed, stamped envelopes provided by the person requesting the notice.

(B) One copy of the full text of the proposed rule, amendment, or rule to be rescinded, accompanied by one copy of the public notice required under division (A) of this section, shall be filed with the secretary of state. Two copies of the full text of the proposed rule, amendment, or rule to be rescinded, accompanied by two copies of the public notice required under division (A) of this section, shall be filed with the director of the legislative service commission. (If in compliance with this division an agency files more than one proposed rule, amendment, or rescission at the same time, and has given a public notice under division (A) of this section that applies to more than one of the proposed rules, amendments, or rescissions, the agency shall file only one copy of the notice with the secretary of state and only two copies of the notice with the director for all of the proposed rules, amendments, or rescissions to which the notice applies.) The proposed rule, amendment, or rescission and public notice shall be filed as required by this division at least sixty days prior to the date on which the agency, in accordance with division (D) of this section, issues an order adopting the proposed rule, amendment, or rescission. The proposed rule, amendment, or rescission shall be available for at

least thirty days prior to the date of the hearing at the office of the agency in printed or other legible form without charge to any person affected by the proposal. Failure to furnish such text to any person requesting it shall not invalidate any action of the agency in connection therewith. If the agency files a substantive revision in the text of the proposed rule, amendment, or rescission under division (H) of this section, it shall also promptly file one copy of the full text of the proposed rule, amendment, or rescission in its revised form with the secretary of state and two copies thereof with the director of the legislative service commission. The agency shall attach a copy of the rule summary and fiscal analysis prepared under section 121.24 or 127.18 of the Revised Code, or both, to each copy of a proposed rule or proposed rule in revised form that is filed with the secretary of state or the director of the legislative service commission.

(C) On the date and at the time and place designated in the notice, the agency shall conduct a public hearing at which any person affected by the proposed action of the agency may appear and be heard in person, by his attorney, or both, may present his position, arguments, or contentions, orally or in writing, offer and examine witnesses, and present evidence tending to show that the proposed rule, amendment, or rescission, if adopted or effectuated, will be unreasonable or unlawful.

At the hearing, the testimony, rulings on the admissibility of evidence, and proffers of evidence shall

be recorded by stenographic means. Such record shall be made at the expense of the agency.

In any hearing under this section the agency may administer oaths or affirmations.

The agency shall pass upon the admissibility of evidence, but the person affected may at the time make objection to the ruling of the agency, and if the agency refuses to admit evidence the person offering the evidence shall make a proffer of the evidence, and the proffer shall be made a part of the record of such hearing.

(D) After complying with divisions (A), (B), (C), and (H) of this section, and when the time for legislative review and invalidation under division (I) of this section has expired, the agency may issue an order adopting the proposed rule or the proposed amendment or rescission of the rule, consistent with the synopsis or general statement included in the public notice. At that time the agency shall designate the effective date of the rule, amendment, or rescission, which shall not be earlier than the tenth day after the rule, amendment, or rescission has been filed in its final form as provided in section 119.04 of the Revised Code.

(E) Prior to the effective date of a rule, amendment, or rescission, the agency shall make a reasonable effort to inform those affected by the rule, amendment, or rescission and to have available for distribution to those requesting it the full text of the rule as adopted or as amended.

(F) If the governor, upon the request of an agency, determines that an emergency requires the immediate adoption, amendment, or rescission of a rule, he shall issue a written order, a copy of which shall be filed with the secretary of state, the director of the legislative service commission, and the joint committee on agency rule review, that the procedure prescribed by this section with respect to the adoption, amendment, or rescission of a specified rule is suspended. The agency may then adopt immediately the emergency rule, amendment, or rescission and it becomes effective on the date copies of the rule, amendment, or rescission, in final form and in compliance with division (A) (2) of section 119.04 of the Revised Code, are filed as follows: two certified copies of the emergency rule, amendment, or rescission shall be filed with both the secretary of state and the director of the legislative service commission, and one certified copy of the emergency rule, amendment, or rescission shall be filed with the joint committee on agency rule review. If all copies are not filed on the same day, the emergency rule, amendment, or rescission shall be effective on the day on which the latest filing is made. The emergency rule, amendment, or rescission shall become invalid at the end of the ninetieth day it is in effect. Prior to that date the agency may adopt the emergency rule, amendment, or rescission as a nonemergency rule, amendment, or rescission by complying with the procedure prescribed by this section for the adoption, amendment, and rescission of nonemergency rules. The agency may not use the procedure of this division to readopt the emergency rule, amendment, or rescission so that, upon

the emergency rule, amendment, or rescission becoming invalid under this division, the emergency rule, amendment, or rescission will continue in effect without interruption for another ninety day period. This division does not apply to the adoption of any emergency rule, amendment, or rescission by the tax commissioner under division (C) (2) of section 5117.02 of the Revised Code.

(G) Rules adopted by an authority within the department of taxation or the bureau of employment services shall be effective without a hearing as provided by this section if the statutes pertaining to such agency specifically give a right of appeal to the board of tax appeals or to a higher authority within the agency or to a court, and also give the appellant a right to a hearing on such appeal. This division does not apply to the adoption of any rule, amendment, or rescission by the tax commissioner under division (C) (1) or (2) of section 5117.02 of the Revised Code, or deny the right to file an action for declaratory judgment as provided in Chapter 2721. of the Revised Code from the decision of the board of tax appeals or of the higher authority within such agency.

(H) When any agency files a proposed rule, amendment, or rescission under division (B) of this section, it shall also file with the joint committee on agency rule review two copies of the full text of the proposed rule, amendment, or rule to be rescinded in the same form and two copies of the public notice required under division (A) of this section. (If in compliance with this division an agency files more than one proposed rule, amendment, or rescission at

the same time, and has given a public notice under division (A) of this section that applies to more than one of the proposed rules, amendments, or rescissions, the agency shall file only two copies of the notice with the joint committee for all of the proposed rules, amendments, or rescissions to which the notice applies.) If the agency makes a substantive revision in a proposed rule, amendment, or rescission after it is filed with the joint committee, the agency shall promptly file two copies of the full text of the proposed rule, amendment, or rescission in its revised form with the joint committee. The latest version of a proposed rule, amendment, or rescission as filed with the joint committee supersedes each earlier version of the text of the same proposed rule, amendment, or rescission. An agency shall attach one copy of the rule summary and fiscal analysis prepared under section 121.24 or 127.18 of the Revised Code, or both, to each copy of a proposed rule, amendment, or rescission, and to each copy of a proposed rule, amendment, or rescission in revised form, that is filed under this division.

This division does not apply to:

(1) An emergency rule, amendment, or rescission;

(2) Any proposed rule, amendment, or rescission that must be adopted verbatim by an agency pursuant to federal law or rule, to become effective within sixty days of adoption, in order to continue the operation of a federally reimbursed program in this state, so long as the proposed rule contains both of the following:

(a) A statement that it is proposed for the purpose of complying with a federal law or rule;

(b) A citation to the federal law or rule that requires verbatim compliance.

(I)(1) The joint committee on agency rule review may recommend the adoption of a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof if it finds any of the following:

(a) That the rule-making agency has exceeded the scope of its statutory authority in proposing the rule, amendment, or rescission;

(b) That the proposed rule, amendment, or rescission conflicts with another rule, amendment, or rescission adopted by thesame or a different rule-making agency;

(c) That the proposed rule, amendment, or rescission conflicts with the legislative intent in enacting the statute under which the rule-making agency proposed the rule, amendment, or rescission;

(d) That the rule-making agency has failed to prepare a complete and accurate rule summary and fiscal analysis of the proposed rule, amendment, or rescission as required by section 121.24 or 127.18 of the Revised Code, or both.

The house of representatives and senate may adopt a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof. The concurrent resolution shall state which of the specific rules, amendments, rescissions, or parts thereof are invalidated. A concurrent resolution invalidating a proposed rule, amendment, or rescission shall be adopted prior to the sixtieth day after the original version of the text of the proposed rule, amendment, or rescission is filed with the joint committee, except that if more than thirty days after the original version is filed the rule-making agency files a revised version of the text of the proposed rule, amendment, or rescission, a concurrent resolution invalidating the proposed rule, amendment, or rescission shall be adopted prior to the thirtieth day after the revised version is filed. If, after the joint committee on agency rule review recommends the adoption of a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof, the house of representatives or senate does not, within the time remaining for adoption of the concurrent resolution, hold five floor sessions at which its journal records a roll call vote disclosing a sufficient number of members in attendance to pass a bill, the time within which that house may adopt the concurrent resolution is extended until it has held five such floor sessions.

Within five days after the adoption of a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof, the clerk of the senate shall send the rule-making agency, the secretary of state, and the director of the legislative service commission a certified copy of the resolution together with a certification stating the date on which the resolution takes effect. The secretary of state and the director of the legislative service commission shall each note the invalidity of the proposed rule, amendment, rescission, or part thereof on this copy, and

shall each remove the invalid proposed rule, amendment, rescission, or part thereof from the file of proposed rules. The rule-making agency shall not proceed to adopt in accordance with division (D) of this section, or to file in accordance with division (B) (1) of section 111.15 of the Revised Code, any version of a proposed rule, amendment, rescission, or part thereof that has been invalidated by concurrent resolution.

Unless the house of representatives and senate adopt a concurrent resolution invalidating a proposed rule, amendment, rescission, or part thereof within the time specified by this division, the rule-making agency may proceed to adopt in accordance with division (D) of this section, or file in accordance with division (B) (1) of section 111.15 of the Revised Code, the latest version of the proposed rule, amendment, or rescission as filed with the joint committee. If by concurrent resolution certain of the rules, amendments, rescissions, or parts thereof are specifically invalidated, the rule-making agency may proceed to adopt, in accordance with division (D) of this section, or to file in accordance with division (B) (1) of section 111.15 of the Revised Code, the latest version of the proposed rules, amendments, rescissions, or parts thereof as filed with the joint committee that are not specifically invalidated. The rule-making agency may not revise or amend any proposed rule, amendment, rescission, or part thereof that has not been invalidated except as provided in this chapter or in section 111.15 of the Revised Code.

(2) (a) A proposed rule, amendment, or rescission that is filed with the joint committee under division (H) of this section or division (D) of section 111.15 of the Revised Code shall be carried over for legislative review to the next succeeding regular session of the

general assembly if the original or any revised version of the proposed rule, amendment, or rescission is filed with the joint committee on or after the first day of December of any year.

(b) The latest version of any proposed rule, amendment, or rescission that is subject to division (1) (2) (a) of this section, as filed with the joint committee, is subject to legislative review and invalidat in the next succeeding regular session of the general assembly in the same manner as if it were the original version of a proposed rule, amendment, or rescission that had been filed with the joint committee for the first time on the first day of the session. A rule-making agency shall not adopt in accordance with division (D) of this section, or file in accordance with division (B) (1) of section 111.15 of the Revised Code, any version of a proposed rule, amendment, or rescission that is subject to division (I) (2) (a) of this section until the time for legislative review and invalidation, as contemplated by division (I) (2) (b) of this section, has expired.

(3) Invalidation of any version of a proposed rule, amendment, rescission, or part thereof by concurrent resolution shall prevent the rule-making agency from instituting or continuing proceedings to adopt any version of the same proposed rule, amendment, rescission, or part thereof for the duration of the general assembly that invalidated the proposed rule, amendment, rescission, or part thereof unless the same general assembly adopts a concurrent resolu-

tion permitting the rule-making agency to institute or continue such proceedings.

The failure of the general assembly to invalidate a proposed rule, amendment, rescission, or part thereof under this section shall not be construed as a ratification of the lawfulness or reasonableness of the proposed rule, amendment, rescission, or any part thereof or of the validity of the procedure by which the proposed rule, amendment, rescission, or any part thereof was proposed or adopted.

5101:3-2-22 Reasonable Cost Reimbursement for Hospital Services

(A) Applicability.
Reasonable cost reimbursement as set forth in this rule applies to:

(1) All outpatient services;

(2) All inpatient services associated with admissions occurring prior to [the] October 1, 1984;

(3) All inpatient services excluded from prospective payment as set forth in rule 5101:3-2-071 of the Administrative Code;

(4) All inpatient services provided under the general relief medical program as described in Chapter 5101:1-6 of the Administrative Code;

(5) All services provided by eligible providers of state-operated institutional psychiatric services as defined in rules 5101:3-2-11 to 5101:3-2-18 of the Administrative Code except that the provisions of 42 CFR 405.460 shall not apply to providers of state-operated institutional psychiatric services;

(6) All capital-related costs described in rule 5101:3-2-076 of the Administrative Code.

(B) Payments under reasonable cost reimbursement.

For hospital services subject to reasonable cost reimbursement, providers will be paid the lesser of reasonable costs or the billed charges for services furnished to eligible recipients. Hospital billings for such services must reflect the hospital's customary charge for the service rendered. Interim payments approximating the allowable costs as established by the provider's cost filings will be made as quickly as administratively feasible and will be computed on an individual basis determined by each institution's reported costs. Reported costs may be adjusted if they exceed predetermined reasonable amounts or if they are for unallowable items.

(1) For hospitals excluded from prospective payment, interim payments will be made by applying the hospital's ratio of total medicaid costs-to-total medicaid charges, expressed as a per cent, to billed charges.

(2) For all hospital services provided to general relief recipients, interim payments will be made by applying the hospital's ratio of total general relief costs-to-total general relief charges, expressed as a per cent, to billed charges.

(3) For outpatient services provided to medicaid recipients by hospitals subject to prospective payment, interim payments will be made by applying the hospital's ratio of total medicaid outpatient charges, expressed as a per cent, to billed charges.

(4) For out-of-state hospitals not subject to the cost-reporting provisions of rule 5101:3-2-23 of the Administrative Code and for new providers, the cost-to-charge ratios are based on the statewide average of the applicable type of ratio.

(5) For transplant services described in rule 5101:3-2-071 and for extraordinary outlier cases described in paragraph (A) (6) of rule 5101:3-2-079 of the Administrative Code, interim payments will be made by applying the hospital's ratio of total medicaid inpatient cost-to-total medicaid inpatient charges, expressed as a per cent, to billed charges except that organ acquisition and transportation costs will be paid at one hundred per cent of billed charges. The hospital-specific cost-to-charge ratio is determined by dividing the hospital-specific medicaid total costs, described in paragraph (D) (6) (e) of rule 5101:3-2-074 of the Administrative Code, by medicaid total charges described in paragraph (D) (6) (b) (i) of rule 5101:3-2-074 of the Administrative Code.

(C) In general, payment will be made for those items recognized as reasonable and allowable under Title XVIII standards and principles described in 42 CFR 405.401 through 405.466 and 405.480 through 405.482 except as otherwise provided in this paragraph. These Title XVIII standards and principles are applicable to those covered inpatient and outpatient hospital services as identified in rules 5101:3-2-01 to 5101:3-2-04 of the Administrative Code which are subject to reasonable cost reimbursement as described in this rule.

(1) The costs identified in paragraphs (C) (1) (a) to (C) (1) (f) of this rule are nonallowable.

(a) Cost of capital improvement or the cost of new equipment subject to a certificate of need approval after November 1, 1976 which has not been approved by the state health planning and development agency (P.L. 93-641).

(b) Cost of goods or services furnished free, by the hospital, or at less than fair market value. For example, the cost of office space or hospital employee time used to prepare physician invoices for physicians who invoice the department on a fee-for-service basis.

(c) Cost of services not reimbursable due to not having been billed timely as defined in rule 5101:3-1-193 of the Administrative Code.

(d) Cost of services which would be or are covered by a third-party payer as described in rule 5101:3-1-08 of the Administrative Code.

(e) The amount of any interest expense for money borrowed to alleviate cash flow problems resulting from rate reductions imposed for delinquent filing of cost reports as provided in rule 5101:3-2-23 of the Administrative Code.

(f) The amount of any interest on overpayments and any interest expense for money borrowed to alleviate cash flow problems resulting from an interest assessment as defined in rule 5101:3-1-25 of the Administrative Code.

(2) Provisions of Title XVIII related to prospective payment for inpatient hospital services as described

in 42 CFR 412.1 through 412.125 are not applicable to hospital services reimbursed under the provisions of this rule. Hospital services described in this rule are reimbursed under the provisions described in paragraphs (C) to (C) (1) (f) of this rule except in instances when those regulations have been altered to accommodate the Title XVIII prospective payment system as indicated in the examples that follow:

(a) Rescinded regulations 42 CFR 405.404, 405.423, and 405.428 as they existed on September 30, 1983, continue to apply under the provisions of this rule.

(b) Amendments made to 42 CFR 405.401 (d) (2) (i), 405.454 (a) (2), 405.454 (m), and 405.463 (c) (1) (iii) to implement Title XVIII prospective payment for certain hospitals are not recognized under the provisions of this rule.

(c) Amendments made to 42 CFR 405.460 (a) (1), 405.460 (h), 405.463 (a) (1), 405.463 (c) (1) (ii), and 405.463 (d) (1) (ii) to remove the applicability of those regulations for the Title XVIII prospective payment system for cost-reporting periods beginning on and after October 1, 1983, are not recognized under the provisions of this rule. Those regulations, as they existed on September 30, 1983, and as applicable to cost-reporting periods prior to those beginning on and after October 1, 1983, continue to apply for purposes of this rule.

(D) For hospitals paid on a prospective basis, a statewide ratio of total medicaid costs-to-total medicaid charges is used in payment for interim claims, as described in paragraph (C) (2) of the rule 5101:3-2-0711 of the Administrative Code. The statewide ratio is determined by summing, for all Ohio medicaid-participating hospitals, total medicaid inpatient charges from "Schedule H," section III, lines 14 and 15, and total medicaid inpatient costs from "Schedule H," section III, lines 6 and 7, then dividing the sum of total costs by the sum of total charges. This ratio is determined annually for each prospective rate year using cost and charge information from hospital cost-reporting periods which end in the calendar year preceding the prospective rate year.